

104TH CONGRESS
1ST SESSION

S. 168

To ensure individual and family security through health insurance coverage
for all Americans.

IN THE SENATE OF THE UNITED STATES

JANUARY 5, 1995

Mr. KENNEDY introduced the following bill; which was read twice and referred
to the Committee on Labor and Human Resources

A BILL

To ensure individual and family security through health
insurance coverage for all Americans.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Affordable Health Care for All Americans Act”.

6 (b) TABLE OF CONTENTS.—The table of contents of
7 this Act is as follows:

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- Sec. 1002. Individual responsibilities.
- Sec. 1003. Protection of consumer choice.
- Sec. 1004. Applicable health plan providing coverage.
- Sec. 1005. Treatment of other nonimmigrants.
- Sec. 1006. Effective date of entitlement.

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- Sec. 1011. General rule of enrollment of family in same health plan.
- Sec. 1012. Treatment of certain families.
- Sec. 1013. Multiple employment situations.

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- Sec. 1101. Provision of comprehensive benefits by plans.
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- Sec. 1200. Participating State.

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- Sec. 1202. Certification of insured health plans.
- Sec. 1203. Establishment of community rating areas.
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- Sec. 1206. Preparation of information concerning plans and purchasing co-operatives.
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- Sec. 1208. Specification of annual general and initial enrollment periods.
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- Sec. 1210. Application of certain State laws.
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- Sec. 1212. Election procedure for community-rated employers.

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- Sec. 1222. General requirements for single-payer systems.
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5 **PART 1—UNIVERSAL COVERAGE**

6 **SEC. 1001. ENTITLEMENT TO HEALTH BENEFITS.**

7 (a) IN GENERAL.—In accordance with this part, each
8 eligible individual is entitled to the benefits required under
9 subtitle B through the applicable health plan in which the
10 individual is enrolled consistent with this title.

11 (b) HEALTH SECURITY CARD.—Each eligible individ-
12 ual is entitled to a health security card to be issued in
13 accordance with this Act.

14 (c) ELIGIBLE INDIVIDUAL DEFINED.—In this Act,
15 the term “eligible individual” means an individual who is
16 residing in the United States and who is—

17 (1)(A) a citizen or national of the United
18 States;

19 (B) a citizen of another country legally residing
20 in the United States (as defined in section 1702(2));
21 or

22 (C) a long-term nonimmigrant (as defined in
23 section 1702(6)); and

24 (2) not an exempt individual (as defined in sec-
25 tion 1702(4)).

1 (d) TREATMENT OF MEDICARE-ELIGIBLE INDIVID-
2 UALS.—Subject to section 1012(a), a medicare-eligible in-
3 dividual is entitled to health benefits under the medicare
4 program instead of the entitlement under subsection (a).

5 **SEC. 1002. INDIVIDUAL RESPONSIBILITIES.**

6 In accordance with this Act, each eligible individual
7 (other than a medicare-eligible individual)—

8 (1) must enroll in an applicable health plan for
9 the individual, and

10 (2) must pay any premium required, consistent
11 with this Act, with respect to such enrollment.

12 **SEC. 1003. PROTECTION OF CONSUMER CHOICE.**

13 Nothing in this Act shall be construed as prohibiting
14 the following:

15 (1) An individual from purchasing any health
16 care services.

17 (2) An individual from purchasing supplemental
18 insurance (offered consistent with this Act) to cover
19 health care services not required to be included in
20 the plan under subtitle B.

21 (3) An individual who is not an eligible individ-
22 ual from purchasing health insurance.

23 (4) Employers from providing coverage for ben-
24 efits in addition to the those described in subtitle B
25 (subject to section 1604).

1 (5) An individual from obtaining (at the ex-
2 pense of such individual) health care from any
3 health care provider of such individual's choice.

4 **SEC. 1004. APPLICABLE HEALTH PLAN PROVIDING COV-**
5 **ERAGE.**

6 Except as otherwise provided:

7 (1) GENERAL RULE: COMMUNITY-RATED
8 HEALTH PLANS.—Except as provided for in regula-
9 tions promulgated by the Secretary to further the
10 purposes of this Act, the applicable health plan for
11 a family is a community-rated health plan for the
12 community-rating area in which the family resides.

13 (2) EXPERIENCE-RATED HEALTH PLANS.—In
14 the case of a family member that is eligible to enroll
15 in an experienced-rated health plan under this title,
16 the applicable health plan for the family is such an
17 experienced-rated health plan.

18 (3) MULTIPLE CHOICE.—Eligible individuals
19 who are permitted to elect coverage under more than
20 one health plan or program referred to in this sub-
21 section may elect which of such plans or programs
22 will be the applicable health plan under this Act.

23 **SEC. 1005. TREATMENT OF OTHER NONIMMIGRANTS.**

24 (a) CERTAIN ALIENS INELIGIBLE FOR BENEFITS.—
25 An alien who is not an eligible individual or otherwise not

1 made eligible under this Act for benefits is not eligible to
2 obtain the benefits required under subtitle B through en-
3 rollment in a health plan under this Act.

4 (b) RECIPROCAL TREATMENT OF OTHER
5 NONIMMIGRANTS.—With respect to those classes of indi-
6 viduals who are lawful nonimmigrants but who are not
7 long-term nonimmigrants (as defined in section 1702),
8 such individuals may obtain such benefits through enroll-
9 ment with community-rated health plans only in accord-
10 ance with such reciprocal agreements between the United
11 States and foreign states as may be entered into.

12 **SEC. 1006. EFFECTIVE DATE OF ENTITLEMENT.**

13 (a) IN GENERAL.—In the case of eligible individuals
14 residing in a State, the entitlement under this part (and
15 requirements under section 1002) shall not take effect
16 until the State becomes a participating State (as defined
17 in section 1200).

18 (b) GENERAL EFFECTIVE DATE DEFINED.—In this
19 Act, the term “general effective date” means January 1,
20 1999.

1 **PART 2—TREATMENT OF FAMILIES AND SPECIAL**
2 **RULES**

3 **SEC. 1011. GENERAL RULE OF ENROLLMENT OF FAMILY IN**
4 **SAME HEALTH PLAN.**

5 (a) IN GENERAL.—Except as provided in this part
6 or otherwise in regulations promulgated by the Secretary
7 to further the purposes of this Act, all members of the
8 same family (as defined by the Secretary) shall be enrolled
9 in the same applicable health plan.

10 (b) CHILD DEFINED.—

11 (1) IN GENERAL.—In this Act, except as other-
12 wise provided, the term “child” means an eligible in-
13 dividual who (consistent with paragraph (3))—

14 (A) is under 25 years of age, and

15 (B) is a dependent of an eligible individual.

16 (2) APPLICATION OF STATE LAW.—Subject to
17 paragraph (3), determinations of whether a person
18 is the child of another person shall be made in ac-
19 cordance with applicable State law.

20 (3) NATIONAL RULES.—The Secretary may es-
21 tablish such national rules respecting individuals
22 who will be treated as children under this Act as the
23 Secretary determines to be necessary. Such rules
24 shall be consistent with the following principles:

1 (A) STEP CHILD.—A child includes a step
2 child who is an eligible individual living with an
3 adult in a regular parent-child relationship.

4 (B) DISABLED CHILD.—A child includes
5 an unmarried dependent eligible individual re-
6 gardless of age who is incapable of self-support
7 because of mental or physical disability which
8 existed before age 21.

9 (C) CERTAIN INTERGENERATIONAL FAMI-
10 LIES.—A child includes the grandchild of an in-
11 dividual if—

12 (i) the parent of the grandchild is a
13 child and the parent and grandchild are
14 living with the grandparent; or

15 (ii) the grandparent has legal custody
16 of the grandchild.

17 (D) TREATMENT OF EMANCIPATED MI-
18 NORS AND MARRIED INDIVIDUALS.—An emanci-
19 pated minor or married individual shall not be
20 treated as a child.

21 (E) CHILDREN PLACED FOR ADOPTION.—
22 A child includes a child who is placed for adop-
23 tion with an eligible individual, except when the
24 child is a child in State supervised care.

1 **SEC. 1012. TREATMENT OF CERTAIN FAMILIES.**

2 (a) TREATMENT OF MEDICARE-ELIGIBLE INDIVID-
3 UALS WHO ARE QUALIFYING EMPLOYEES OR SPOUSES OF
4 QUALIFYING EMPLOYEES.—

5 (1) IN GENERAL.—Except as specifically pro-
6 vided, in the case of an individual who is an individ-
7 ual described in paragraph (2) with respect to 2 con-
8 secutive months in a year (and it is anticipated
9 would be in the following month and in such follow-
10 ing month would be a medicare-eligible individual),
11 the individual shall be treated as an eligible individ-
12 ual under this Act during such following month and
13 the remainder of the year. Nothing in this section
14 shall be construed to affect any entitlement under
15 title XVII of the Social Security Act.

16 (2) INDIVIDUAL DESCRIBED.—An individual de-
17 scribed in this paragraph with respect to a month is
18 an individual who is a qualifying employee or the
19 spouse or family member of a qualifying employee in
20 the month.

21 (b) SEPARATE TREATMENT FOR CERTAIN GROUPS
22 OF INDIVIDUALS.—In the case of a family that includes
23 one or more individuals in a group described in subsection
24 (c)—

1 (1) all the individuals in each such group within
2 the family shall be treated collectively as a separate
3 family, and

4 (2) all the individuals not described in any such
5 group shall be treated collectively as a separate
6 family.

7 (c) GROUPS OF INDIVIDUALS DESCRIBED.—Each of
8 the following is a group of individuals described in this
9 subsection:

10 (1) AFDC recipients.

11 (2) Disabled SSI recipients.

12 (3) SSI recipients who are not disabled SSI re-
13 cipients.

14 (d) QUALIFYING STUDENTS.—

15 (1) IN GENERAL.—In the case of a qualifying
16 student (described in paragraph (2)), the student
17 may elect to enroll in a community-rate health plan
18 offered for the health care coverage area in which
19 the school is located.

20 (2) QUALIFYING STUDENT.—In paragraph (1),
21 the term “qualifying student” means an individual
22 who—

23 (A) but for this subsection would receive
24 coverage under a health plan as a child of an-
25 other person, and

1 (B) is a full-time student at a school in a
2 health care coverage area that is different from
3 the area (or, in the case of a large group spon-
4 sor, such coverage area as the Secretary may
5 specify) providing the coverage described in
6 subparagraph (A).

7 **SEC. 1013. MULTIPLE EMPLOYMENT SITUATIONS.**

8 In the case of an individual who is eligible as a quali-
9 fied employee, or a spouse of such an employee, for cov-
10 erage under more than one health plan, the individual and
11 the spouse of the individual shall elect the applicable
12 health plan.

13 **Subtitle B—Benefits**

14 **SEC. 1101. PROVISION OF COMPREHENSIVE BENEFITS BY**
15 **PLANS.**

16 (a) IN GENERAL.—A certified health plan shall pro-
17 vide benefits that are actuarially equivalent to the benefits
18 provided under the Blue Cross/Blue Shield standard op-
19 tion plan which is provided under the Federal Employees
20 Health Benefits Program on January 1, 1995.

21 (b) COVERAGE OF SERVICES.—A certified health plan
22 shall provide coverage under subsection (a) for at least
23 the following services:

24 (1) Hospital services.

25 (2) Services of health professionals.

1 (3) Emergency and ambulatory medical and
2 surgical services.

3 (4) Clinical preventive services.

4 (5) Mental illness and substance abuse services.

5 (6) Family planning services and services for
6 pregnant women.

7 (7) Hospice care, home health care, extended
8 care services, outpatient rehabilitation services, and
9 ambulance services.

10 (8) Outpatient laboratory, radiology, and diag-
11 nostic services.

12 (9) Outpatient prescription drugs and
13 biologicals.

14 (10) Durable medical equipment, including
15 hearing aids for children, and prosthetic and orthotic
16 devices.

17 (11) Vision care and dental care for children.

18 (12) Patient care costs of qualified investiga-
19 tional treatments.

20 (c) MEDICAL NECESSITY.—

21 (1) IN GENERAL.—A certified health plan shall
22 not be required to provide services that are not
23 medically necessary or appropriate.

24 (2) SCOPE OR DURATION.—A certified health
25 plan may not impose any limitations on the scope or

1 duration of any medically necessary or appropriate
2 services described in paragraphs (1), (2), (3), (6),
3 (8), (9), or (12). Such a plan may not apply a life-
4 time limit with respect to any such service and may
5 not exclude people with congenital conditions from
6 the same type of coverage as persons needing care
7 as a result of illness or injury.

8 (3) LIMITATIONS.—The following services shall
9 not be considered medically necessary or appro-
10 priate:

11 (A) In vitro fertilization services.

12 (B) Sex change surgery and related serv-
13 ices.

14 (C) Surgery and other procedures per-
15 formed solely for cosmetic purposes and hos-
16 pital or other services incident thereto, unless—

17 (i) required to correct a congenital
18 anomaly; or

19 (ii) required to restore or correct a
20 part of the body that has been altered as
21 a result of—

22 (I) accidental injury;

23 (II) disease; or

24 (III) surgery that is otherwise
25 covered under this subtitle.

1 (d) PREVENTIVE AND PRENATAL SERVICES.—

2 (1) IN GENERAL.—The clinical preventive serv-
3 ices that are required under subsection (b)(4) are
4 those services specified by the Secretary. Such speci-
5 fications shall include the periodicity schedules for
6 such services and special coverage or periodicity
7 schedules for high risk populations, if appropriate.
8 In developing such specifications the Secretary shall
9 consult with—

10 (A) medical experts and insurers;

11 (B) the United States Preventive Service
12 Task Force;

13 (C) the American Academy of Pediatrics,
14 with respect to preventive services for children;

15 (D) the American College of Obstetricians
16 and Gynecologists, with respect to preventive
17 services for women.

18 (2) COST SHARING.—

19 (A) IN GENERAL.—Except as provided in
20 subparagraph (B), a certified health plan may
21 not impose any cost-sharing requirements with
22 respect to clinical preventive services and pre
23 natal care services.

24 (B) NETWORK PLANS.—In the case of a
25 certified health plan that is a network plan, the

1 requirement of subparagraph (A) shall not
2 apply if the services described in such subpara-
3 graph are obtained from an out-of-network pro-
4 vider.

5 (e) MENTAL ILLNESS AND SUBSTANCE ABUSE SERV-
6 ICES.—The mental illness and substance abuse services
7 that are required described under subsection (b)(5) are
8 those services that meet the minimum standards for cov-
9 erage of inpatient, residential, intensive nonresidential,
10 and outpatient services as specified by the Secretary. Such
11 standards shall ensure that effective beginning in 2001,
12 there will be parity in the coverage of mental health serv-
13 ices.

14 (f) HEALTH PROFESSIONAL SERVICES.—As used in
15 subsection (b)(2), the term “health professional services”
16 means professional services that are lawfully provided by
17 a physician or professional services that could be lawfully
18 provided by a physician but are provided by another health
19 professional who is legally authorized to provide such serv-
20 ices in the State in which the services are provided.

21 (g) ACTUARIAL EQUIVALENCY.—In calculating actu-
22 arial equivalency under subsection (a), a certified health
23 plan shall exclude clinical preventive services and mental
24 illness and substance abuse services that are provided
25 under the plan or under the Blue Cross/Blue Shield stand-

1 and option plan under the Federal Employees Health Ben-
 2 efits Program.

3 (h) MODEL PLANS.—The Secretary, in consultation
 4 with the NAIC, insurers, employers, consumers, and medi-
 5 cal experts shall establish three model certified health
 6 plans for consideration by plan sponsors, of which—

7 (1) one plan shall have cost-sharing and scope
 8 and duration limits that are appropriate for fee-for-
 9 service plans that are actuarially equivalent to the
 10 Blue Cross/Blue Shield standard option plan;

11 (2) one plan shall have cost-sharing and scope
 12 and duration limits that are appropriate for pre-
 13 ferred provider network plans that are actuarially
 14 equivalent to the Blue Cross/Blue Shield standard
 15 option plan; and

16 (3) one plan shall have cost-sharing and scope
 17 and duration limits that are appropriate for health
 18 maintenance organizations that are actuarially
 19 equivalent to the Blue Cross/Blue Shield standard
 20 option plan.

21 (i) QUALIFIED INVESTIGATIONAL TREATMENTS.—

22 (1) IN GENERAL.—As used in subsection
 23 (b)(13), the term “qualified investigational treat-
 24 ment” means an investigational treatment that is
 25 part of a peer-reviewed and approved research pro-

1 gram (as defined by the Secretary) or research trials
2 approved by the Secretary. A certified health plan
3 shall not be required to cover any patient care costs
4 associated with such treatments if such cost would
5 normally be covered by another party as determined
6 under regulations promulgated by the Secretary.

7 (2) APPROVAL OF RESEARCH TRIALS.—A re-
8 search trial is deemed to be approved for purposes
9 of this subsection if such trial is approved by one or
10 more of the following:

11 (A) The National Institutes of Health.

12 (B) The Food and Drug Administration
13 (through an investigational new drug exemption
14 pursuant to section 505 of the Federal Food,
15 Drug, and Cosmetic Act (21 U.S.C. 355) or an
16 investigational device exemption pursuant to
17 section 520(g) of such Act (21 U.S.C.
18 360j(g))).

19 (C) The Department of Veterans Affairs.

20 (D) The Department of Defense.

21 (E) A qualified nongovernmental research
22 entity as defined in guidelines issued by one or
23 more of the National Institutes of Health, in-
24 cluding guidelines for cancer center support

1 grants designated by the National Cancer Insti-
2 tute.

3 (j) STUDY AND REPORT.—

4 (1) STUDY.—The Secretary shall conduct a
5 study concerning the provision and enrollment pat-
6 terns of certified health plans.

7 (2) REPORT.—Not later than 5 years after the
8 date of enactment of this Act, the Secretary shall
9 prepare and submit to the appropriate committees of
10 Congress a report concerning the study conducted
11 under paragraph (1). Such report shall include a de-
12 termination by the Secretary of whether the stand-
13 ardization of certified health plan offerings would be
14 appropriate to assist consumers in choosing among
15 such plans based on cost and quality or to avoid
16 plan design practices intended to attract better risks
17 and resulting in poorer availability of reasonably
18 priced coverage for individuals needing greater than
19 average utilization of health care services.

20 **SEC. 1102. PROVISION OF ITEMS OR SERVICES CONTRARY**
21 **TO RELIGIOUS BELIEF OR MORAL CONVIC-**
22 **TION.**

23 A health professional or a health facility may not be
24 required to provide an item or service under a certified

1 health plan if the professional or facility objects to doing
 2 so on the basis of a religious belief or moral conviction.

3 **SEC. 1103. BALANCE BILLING.**

4 The Secretary shall provide for methods to ensure the
 5 prohibition of balance billing.

6 **Subtitle C—State Role in Reform**

7 **SEC. 1200. PARTICIPATING STATE.**

8 (a) IN GENERAL.—As used in this title, the term
 9 “participating State” means a State that meets the appli-
 10 cable requirements of this Act, including the requirement
 11 for the establishment of a market reform program de-
 12 scribed in this subtitle and the administration of subsidies
 13 as provided for in title V.

14 (b) REFORM PLAN.—To become a participating State
 15 under this section, a State shall submit to the Secretary
 16 a reform plan describing a health care system meeting the
 17 requirements of this Act that the State intends to estab-
 18 lish (or has established), update such plan at time periods
 19 and in a manner specified by the Secretary, and imple-
 20 ment such plan.

21 (c) DEADLINE FOR PARTICIPATION.—If a State is
 22 not a participating State by January 1, 1999, the provi-
 23 sions of section 1521 (relating to the Federal govern-
 24 ment’s role in the case of default by a State) shall apply

1 to such State. A State may not be a participating State
2 prior to January 1, 1997.

3 **PART 1—STATE MARKET REFORM**

4 **SEC. 1201. ESTABLISHMENT OF STATE MARKET REFORM**
5 **PROGRAMS.**

6 (a) IN GENERAL.—Each State shall establish a State
7 market reform program that meets the requirements of
8 this title.

9 (b) DEADLINE.—Each State shall establish and have
10 in operation a State market reform program by not later
11 than January 1, 1997, to carry out this title. Such pro-
12 gram shall provide for the enrollment of individuals in cer-
13 tified health plans by not later than such date.

14 (c) PERIODIC SECRETARIAL REVIEW OF STATE PRO-
15 GRAMS.—

16 (1) IN GENERAL.—The Secretary may periodi-
17 cally review State programs established under sub-
18 section (a) to determine if such programs meet the
19 requirements of this subtitle.

20 (2) REPORTING REQUIREMENTS OF STATES.—
21 For purposes of paragraph (1), each State shall sub-
22 mit to the Secretary, at intervals established by the
23 Secretary, a report on the compliance of the State
24 with the requirements of this subtitle.

1 **SEC. 1202. CERTIFICATION OF INSURED HEALTH PLANS.**

2 (a) IN GENERAL.—Each State market reform pro-
3 gram shall provide for the certification of insured health
4 plans as certified health plans if the appropriate certifying
5 authority finds that the plan meets the applicable require-
6 ments for certification under this title.

7 (b) NONDISCRIMINATION AGAINST OUT-OF-STATE
8 PLANS AND PROVIDERS.—A State—

9 (1) may not discriminate against any health
10 plan because such plan is domiciled in another
11 State; and

12 (2) may not limit the ability of any health plan
13 to contract with a health care provider because such
14 plan or such provider is located outside the bound-
15 aries of such State.

16 **SEC. 1203. ESTABLISHMENT OF COMMUNITY RATING**
17 **AREAS.**

18 (a) ESTABLISHMENT.—Each State program shall
19 provide, by not later than January 1, 1996, for the divi-
20 sion of the State into 1 or more community rating areas.
21 The program may revise the boundaries of such areas
22 from time to time consistent with this section.

23 (b) MULTIPLE AREAS.—With respect to a community
24 rating area—

1 (1) no metropolitan statistical area in a State
2 may be incorporated into more than 1 community
3 rating area in such State;

4 (2) the number of individuals residing within a
5 community rating area may not be less than
6 250,000 (and shall respect the existing referral pat-
7 terns within market areas); and

8 (3) no area incorporated in a community rating
9 area may be incorporated into another community
10 rating area.

11 (c) INTERSTATE AREAS.—Two or more contiguous
12 States are encouraged to provide for the establishment of
13 a common community rating area that includes adjoining
14 portions of the States if the market area extends across
15 State lines, so long as all portions of any metropolitan sta-
16 tistical area within such States are within the same com-
17 munity rating area.

18 (d) SPECIAL OR UNDERSERVED POPULATIONS.—In
19 establishing community rating areas, the State shall take
20 into consideration the needs of special or underserved pop-
21 ulations.

22 (e) DISCRIMINATION.—A State may not establish
23 boundaries for community rating areas in a manner that
24 has the effect of discriminating on the basis of any cat-
25 egory described in section 1414.

1 **SEC. 1204. PROCEDURES FOR CERTIFICATION OF PUR-**
2 **CHASING COOPERATIVES.**

3 Each State market reform program shall establish a
4 process for the certification of purchasing cooperatives
5 consistent with part 2 of subtitle D.

6 **SEC. 1205. COORDINATION AMONG PURCHASING COOPERA-**
7 **TIVES.**

8 Each State shall establish rules consistent with part
9 2 of subtitle D for the coordination among purchasing co-
10 operatives with respect to enrollment, payment of pre-
11 miums, and provision of out-of-area benefits and services.

12 **SEC. 1206. PREPARATION OF INFORMATION CONCERNING**
13 **PLANS AND PURCHASING COOPERATIVES.**

14 (a) IN GENERAL.—Each State market reform pro-
15 gram shall prepare and make available to purchasing co-
16 operatives, employers and to individuals located in the
17 State information, in standardized comparative form as
18 required under the program, concerning the health plans
19 certified by such State and purchasing cooperatives oper-
20 ating in the State.

21 (b) ACCESS TO PLANS AND COOPERATIVES.—Each
22 State shall provide information to employers and individ-
23 uals describing how to access each community-rated health
24 plan and purchasing cooperative in the area.

1 **SEC. 1207. RISK ADJUSTMENT PROGRAM.**

2 Each State market reform program shall provide for
3 a risk adjustment program for community-rated and asso-
4 ciation health plans that meets the standards developed
5 by the Secretary under section 1417.

6 **SEC. 1208. SPECIFICATION OF ANNUAL GENERAL AND INI-**
7 **TIAL ENROLLMENT PERIODS.**

8 (a) ANNUAL GENERAL ENROLLMENT PERIOD.—
9 Each State market reform program shall specify an an-
10 nual period, of not less than 30 days, during which an
11 eligible individual in the State may enroll in a certified
12 health plan or change the certified health plan in which
13 the individual is enrolled.

14 (b) INITIAL ENROLLMENT PERIOD.—Each State
15 market reform program shall specify an initial enrollment
16 period in 1996 of not less than 45 days, during which indi-
17 viduals in the State may enroll in certified health plans
18 for coverage beginning as of January 1, 1997.

19 **SEC. 1209. SPECIAL RULES REGARDING NETWORK PLANS.**

20 A State market reform program may grant a network
21 plan a certification to operate in a service area which is
22 not identical to the borders of a community rating area
23 if the network plan has demonstrated to the satisfaction
24 of the State that the plan has met the requirements of
25 section 1411(a)(4).

1 **SEC. 1210. APPLICATION OF CERTAIN STATE LAWS.**

2 Upon the application of a State, and the approval of
3 such application by the Secretary, the State may—

4 (1) tighten premium rate bands beyond the var-
5 iation permitted under section 1413;

6 (2) establish rules for association plans that are
7 more restrictive than those provided for under part
8 3 of subtitle D if, in the judgement of the Secretary,
9 such rules increase the viability of the community-
10 rated market; and

11 (3) establish financial solvency requirements
12 that exceed the requirements of section 1418.

13 **SEC. 1211. CONSUMER ADVOCATE.**

14 (a) IN GENERAL.—The Secretary shall establish (by
15 grant or contract) and oversee a National Center of
16 Consumer Advocacy to provide technical assistance, ade-
17 quate training and support to States and Offices of
18 Consumer Advocacy in each State (hereafter referred to
19 in this section as the “Office”) to carry out the duties
20 of this section, including providing public education to
21 consumers concerning this Act. The National Center of
22 Consumer Advocacy shall be a national non-profit organi-
23 zation with public education and health policy expertise
24 and shall have sufficient staff to carry out its duties and
25 a demonstrated ability to represent and work with a broad
26 spectrum of consumers, including vulnerable and under

1 served populations. The Office in each State shall perform
2 public outreach and provide education and assistance re-
3 garding consumer rights and responsibilities under this
4 Act, and assist consumers in dealing with problems that
5 arise with consumer purchasing cooperatives, experience-
6 rated employers, health plans, and health care providers
7 operating in such State.

8 (b) CONTRACTS.—

9 (1) SOLICITATION.—The Secretary shall solicit
10 contracts from private non-profit organizations to
11 fulfill the duties of the Office in the State. The Sec-
12 retary may develop such regulations and guidelines
13 as necessary to oversee the process of considering
14 and awarding competitive contracts under this sec-
15 tion. In awarding such contracts, the Secretary shall
16 consult with the State and National Center of
17 Consumer Advocacy, and shall, at a minimum, con-
18 sider the demonstrated ability of the organization to
19 represent and work with a broad spectrum of con-
20 sumers, including vulnerable and underserved popu-
21 lations.

22 (2) CONTRACT PERIOD.—The contract period
23 for the State Offices of Consumer Advocacy and the
24 National Center of Consumer Advocacy under this

1 section shall be not less than 4 years and not more
2 than 7 years.

3 (c) FUNCTIONS AND RESPONSIBILITIES.—Each Of-
4 fice shall have sufficient staff, local offices throughout the
5 State, and a State-wide toll-free hotline to carry out the
6 duties of this section. Through direct contact and the hot-
7 line, the Office shall provide the following services in the
8 State, including appropriate assistance to individuals with
9 limited English language ability—

10 (1) outreach and education relating to
11 consumer rights and responsibilities under this Act,
12 including such rights and services available through
13 the Office;

14 (2) assistance with enrollment in health plans,
15 or obtaining services or reimbursement from health
16 plans;

17 (3) assistance with filing an application for pre-
18 mium or cost sharing subsidies;

19 (4) information to enrollees about existing
20 grievance procedures and coordination with other en-
21 tities to assist in identifying, investigating, and re-
22 solving enrollee grievances under this Act (including
23 grievances before State medical boards);

24 (5) regular and timely access in the area to the
25 services provided through the Office and its local of-

1 fices and timely responses from representatives of
2 the Office to complaints;

3 (6) referrals to appropriate local providers of
4 legal assistance and to appropriate State and Fed-
5 eral agencies which may be of assistance to ag-
6 grieved individuals in the area; and

7 (7) conduct public hearings no less frequently
8 than once a year to identify and address community
9 health care needs.

10 (d) ACCESS TO INFORMATION.—The Secretary and
11 the States shall ensure that, for purposes of carrying out
12 the Office's duties under this section, the Office (and offi-
13 cers and employees of the Office in local offices) have ap-
14 propriate access to relevant information subject to protec-
15 tions for confidentiality of enrollee information.

16 (e) EVALUATION AND REPORT.—The Secretary shall
17 have the right to evaluate the quality and effectiveness of
18 the organization in carrying out the functions specified in
19 the contract. The Office shall report to the Secretary and
20 the State annually on the nature and patterns of consumer
21 complaints received in the Office and its local offices dur-
22 ing each year and any policy, regulatory, and legislative
23 recommendations for needed improvements together with
24 a record of the activities of the Office.

1 (f) CONFLICTS OF INTEREST.—The Secretary shall
 2 ensure that no individual involved in the designation of
 3 the Office, the Office itself, or of any delegate thereof is
 4 subject to a conflict of interest, including affiliation with
 5 (through ownership or common control) a health care fa-
 6 cility, managed care organization, health insurance com-
 7 pany or association of health care facilities or providers.
 8 No grantee under this part may have a direct involvement
 9 with the licensing, certification, or accreditation of a
 10 health care facility, a health care plan, or a provider of
 11 health care services.

12 (g) LEGAL COUNSEL.—The Secretary shall ensure
 13 that adequate legal counsel is available, and is able, with-
 14 out conflict of interest, to assist the Office, and the local
 15 offices thereof in the performance of their official duties.

16 **SEC. 1212. ELECTION PROCEDURE FOR COMMUNITY-RATED**
 17 **EMPLOYERS.**

18 (a) IN GENERAL.—Each participating State shall es-
 19 tablish a procedure (consistent with rules established by
 20 the Board) through which exempt employers, as defined
 21 in section 6117, may make an election to be treated as
 22 a community-rated employer. Such procedure shall set
 23 forth the form and manner that such election shall be
 24 made.

1 (b) NOTIFICATION.—The procedure shall require that
 2 employees of a exempt employer are notified of an election
 3 or a termination of an election under this section prior
 4 to the first annual open enrollment period (as defined in
 5 section 1660) following such election or termination.

6 (c) TERMINATION.—The procedures shall permit ex-
 7 empt employers to terminate an election made under this
 8 section. If an employer terminates an election, the termi-
 9 nation shall be effective on the first date of the year fol-
 10 lowing such termination.

11 **PART 2—REQUIREMENTS FOR STATE SINGLE-**
 12 **PAYER SYSTEMS**

13 **SEC. 1221. SINGLE-PAYER SYSTEM DESCRIBED.**

14 The Secretary may approve an application of a State
 15 to operate a single-payer system if the Secretary finds that
 16 the system meets the requirements of sections 1222 and
 17 1223.

18 **SEC. 1222. GENERAL REQUIREMENTS FOR SINGLE-PAYER**
 19 **SYSTEMS.**

20 Each single-payer system shall meet the following re-
 21 quirements:

22 (1) ESTABLISHMENT BY STATE.—The system is
 23 established under State law, and State law provides
 24 for mechanisms to enforce the requirements of the
 25 system.

1 (2) OPERATION BY STATE.—The system is op-
2 erated by the State or a designated agency of the
3 State.

4 (3) ENROLLMENT OF INDIVIDUALS.—

5 (A) MANDATORY ENROLLMENT.—The sys-
6 tem shall provide for the enrollment of all indi-
7 viduals residing in the State who are not medi-
8 care-eligible individuals, except that the Sec-
9 retary may through regulation except appro-
10 priate individuals from the requirements of this
11 subparagraph and such requirements shall not
12 apply to the individuals described in subpara-
13 graph (B).

14 (B) EXCLUSION OF CERTAIN INDIVID-
15 UALS.—A single-payer system may not require
16 the enrollment of veterans, active duty military
17 personnel, and American Indians.

18 (4) DIRECT PAYMENT TO PROVIDERS.—

19 (A) IN GENERAL.—With respect to provid-
20 ers who furnish items and services required
21 under subtitle B to individuals enrolled in the
22 system, the State shall make payments directly,
23 or through fiscal intermediaries, to such provid-
24 ers and assume (subject to subparagraph (B))

1 all financial risk associated with making such
2 payments.

3 (B) CAPITATED PAYMENTS PERMITTED.—

4 Nothing in subparagraph (A) shall be construed
5 to prohibit providers furnishing items and serv-
6 ices under the system from receiving payments
7 on a capitated, at-risk basis based on prospec-
8 tively determined rates.

9 (5) PROVISION OF BENEFITS.—

10 (A) IN GENERAL.—The system shall pro-
11 vide for coverage of items and services required
12 under subtitle B, including the cost-sharing
13 provided under the plan (subject to subpara-
14 graph (B)), to all individuals enrolled in the
15 system.

16 (B) IMPOSITION OF REDUCED COST-SHAR-
17 ING.—The system may decrease the cost-shar-
18 ing otherwise provided in under subtitle B with
19 respect to any individuals enrolled in the system
20 or any class of services included in the items
21 and services under such subtitle, so long as the
22 system does not increase the cost-sharing other-
23 wise imposed with respect to any other individ-
24 uals or services.

1 (6) COST CONTAINMENT.—The system shall
 2 provide for mechanisms to ensure, in a manner sat-
 3 isfactory to the Secretary, that—

4 (A) the rate of growth in health care
 5 spending will not be higher than the National
 6 rate of growth;

7 (B) the expenditures described in subpara-
 8 graph (A) are computed and effectively mon-
 9 itored; and

10 (C) Federal payments to a single payer
 11 State shall be limited to the payments that
 12 would have been made in the absence of the im-
 13 plementation of the single payer system.

14 (7) REQUIREMENTS GENERALLY APPLICABLE
 15 TO CERTIFIED HEALTH PLANS.—The system shall
 16 meet the appropriate requirements applicable to a
 17 certified health plan, as determined by the Sec-
 18 retary.

19 **SEC. 1223. ADDITIONAL RULES FOR SINGLE-PAYER SYSTEM.**

20 (a) IN GENERAL.—In the case of a State operating
 21 a single-payer system—

22 (1) the State shall operate the system through-
 23 out the State;

1 (2) except as provided in subsection (b), the
 2 State shall meet the requirements for participating
 3 States under part 1; and

4 (3) the State shall not use any funds collected
 5 pursuant to section 1221 and 1222 or any earnings
 6 on such funds for any reason other than to pay
 7 health care claims or provide health care benefits.

8 (b) EXCEPTIONS TO CERTAIN REQUIREMENTS FOR
 9 PARTICIPATING STATES.—In the case of a State operating
 10 a single-payer system, the State is not required to meet
 11 any requirements that the Secretary determines are not
 12 appropriate to apply to a State single-payer system.

13 (c) SINGLE-PAYER STATE DEFINED.—In this title,
 14 the term “single-payer State” means a State with a single-
 15 payer system in effect that has been approved by the Sec-
 16 retary in accordance with this part.

17 **Subtitle D—Expanded Access to** 18 **Health Plans**

19 **PART 1—ACCESS THROUGH EMPLOYERS**

20 **SEC. 1301. EMPLOYER ACCESS AND ENROLLMENT RE-** 21 **QUIREMENTS.**

22 (a) IN GENERAL.—Each employer shall—

23 (1) make available to each employee of the em-
 24 ployer the opportunity to enroll through the em-
 25 ployer in one of at least three certified health plans,

1 if available, including either a fee-for-service plan or
 2 a health plan with a point-of-service option, and

3 (2) to provide payroll withholding of any re-
 4 quired employee premiums.

5 If an employer desires to satisfy the requirement of para-
 6 graph (1) by offering a point-of-service plan, cost-sharing
 7 for out-of-network services shall not be substantially
 8 greater than those applied by fee-for-service plans.

9 (b) SPECIAL RULES.—

10 (1) PURCHASING COOPERATIVE.—A small em-
 11 ployer may meet the requirements of subsection
 12 (a)(1) through a purchasing cooperative.

13 (2) LARGE EMPLOYER.—

14 (A) IN GENERAL.—A large employer shall
 15 meet the requirements of subsection (a)(1) only
 16 through offering experience-rated health plans.

17 (B) SINGLE INSURER.—Nothing in this
 18 section shall be construed as preventing or re-
 19 quiring a large employer from complying with
 20 subsection (a)(1) through the offering of plans
 21 by a single insurer.

22 **SEC. 1302. SMALL EMPLOYER REQUIREMENTS.**

23 (a) PAYROLL DEDUCTION.—Upon authorization
 24 from an employee, a small employer shall deduct from the
 25 employee's wages the employee's share of any premium

1 due to a certified health plan or purchasing cooperative.
2 Except as provided in subsection (c), this subsection shall
3 only apply to plans made available, either directly or
4 through a purchasing cooperative, by the employer.

5 (b) NO REQUIREMENT TO ENROLL IN EMPLOYER-
6 PROVIDED PLAN.—A community-rated individual who is
7 an employee of a small employer may elect not to enroll
8 in a certified health plan offered by such employer under
9 this section. Such an employee may enroll in any certified
10 health plan offered in the community rating area in which
11 the employee works or in which the employee resides (in-
12 cluding certified health plans offered through purchasing
13 cooperatives serving such area).

14 (c) DEDUCTION AND CONTRIBUTION IN THE CASE
15 OF FEHBP PLANS.—In the case of an election described
16 in subsection (c) by an employee of a small employer to
17 enroll in an FEHBP plan made available under section
18 1331, the small employer shall make the payroll deduction
19 described in subsection (b) and shall forward the employ-
20 er's contribution, if any, to such FEHBP plan. The em-
21 ployer may charge a reasonable administrative fee for such
22 activities.

PART 2—ACCESS TO PURCHASING**COOPERATIVES****SEC. 1311. ESTABLISHMENT OF COOPERATIVES.**

A State may establish or charter purchasing cooperatives in accordance with this subtitle for the purpose of improving access to health plans, reducing the cost of health insurance, and improving the quality of care. Each purchasing cooperative established in a State shall be certified under State law.

SEC. 1312. CONFLICT OF INTEREST.

An insurer, agent, broker or any other individual or entity otherwise engaged in the sale of health insurance may not form or underwrite a purchasing cooperative or hold or control any right to vote with respect to a purchasing cooperative.

SEC. 1313. MEMBERSHIP.

A purchasing cooperative shall accept all small employers and individuals eligible for coverage in the community-rated market and residing within the area served by the cooperative if such employers or individuals request such membership. A purchasing cooperative shall conduct enrollment, outreach and marketing activities in a manner that provides individuals and employers with ready access and availability to cooperative health plans throughout the community-rating area served by the cooperative.

1 **SEC. 1314. BOARD OF DIRECTORS.**

2 A purchasing cooperative established under this part
3 shall be governed by a board of directors or receive active
4 input from an advisory board consisting of individuals and
5 businesses participating in the cooperative.

6 **SEC. 1315. CHOICE OF HEALTH PLANS.**

7 A purchasing cooperative shall enter into agreements
8 with at least three certified health plans (if available) pro-
9 viding the comprehensive benefits described in subtitle B,
10 including (if available) at least one fee-for-service plan or
11 point-of-service plan meeting the requirements described
12 in section 1301.

13 **SEC. 1316. LIMITATION ON ACTIVITIES.**

14 A purchasing cooperative shall not—

15 (1) perform any activity involving approval or
16 enforcement of payment rates for providers;

17 (2) perform any activity (other than the report-
18 ing of noncompliance) relating to compliance of cer-
19 tified health plans with the requirements of this Act;

20 (3) assume financial risk in relation to any such
21 health plan; or

22 (4) perform other activities identified by the
23 State as being inconsistent with the performance of
24 its duties under this Act.

1 **SEC. 1317. VOLUNTARY PARTICIPATION.**

2 Nothing in this part shall be construed as requiring
3 any individual or small employer to purchase a certified
4 health plan exclusively through a purchasing cooperative.

5 **PART 3—ACCESS THROUGH ASSOCIATION PLANS**

6 **Subpart A—Certified Association Plans**

7 **SEC. 1321. TREATMENT OF CERTIFIED ASSOCIATION**
8 **PLANS.**

9 For purposes of this Act, in the case of a certified
10 association plan—

11 (1) except as otherwise provided in this sub-
12 part, the plan shall be required to meet all applicable
13 requirements of this Act for certified health plans
14 offered by large employers,

15 (2) if such plan is certified as meeting such re-
16 quirements, such plan shall be treated as a health
17 plan established and maintained by a large employer
18 and individuals enrolled in such plan shall be treated
19 as experience-rated individuals,

20 (3) any individual who is a member of the asso-
21 ciation not enrolling in the plan shall not be treated
22 as an experience-rated individual solely by reason of
23 membership in such association, and

24 (4) such plan shall cover at least 500 lives on
25 and after the date of enactment of this Act.

1 **SEC. 1322. MODIFICATIONS OF STANDARDS APPLICABLE TO**
2 **CERTIFIED ASSOCIATION PLANS.**

3 (a) CERTIFYING AUTHORITY.—

4 (1) MULTISTATE CERTIFIED ASSOCIATION
5 SELF-INSURED PLANS.—For purposes of this Act,
6 the Secretary of Labor shall be the appropriate cer-
7 tifying authority with respect to a certified associa-
8 tion plan which is a multistate self-insured health
9 plan.

10 (2) SINGLE STATE CERTIFIED ASSOCIATION
11 SELF-INSURED PLANS.—For purposes of this Act,
12 the State shall be the appropriate certifying author-
13 ity with respect to a certified association plan which
14 is a single State self-insured health plan.

15 (b) RISK ADJUSTMENT.—The requirements of sec-
16 tion 1417 shall apply to a plan described in section 1321.

17 (c) CAPITAL REQUIREMENTS.—Not later than 9
18 months after the date of enactment of this Act, the Sec-
19 retary of Labor, in consultation with the NAIC, shall es-
20 tablish solvency standards for health plans described in
21 section 1321, and rules for monitoring and enforcing com-
22 pliance with such standards. Such requirements shall be
23 the applicable plan standards with respect to such plans
24 in lieu of the requirements of section 1418.

25 (d) AVAILABILITY.—A certified association plan may
26 only include in coverage any business or individual who

1 is a member of the association establishing or maintaining
2 the plan, an employee of such member, or a spouse or de-
3 pendent of either.

4 **SEC. 1323. ASSOCIATION PLAN DEFINED.**

5 (a) IN GENERAL.—The term “association plan”
6 means a health plan which—

7 (1) is (or is a continuation of) an existing plan,
8 and

9 (2) is established or maintained by a qualified
10 association.

11 (b) EXISTING PLAN.—For purposes of this section—

12 (1) IN GENERAL.—A health plan is an existing
13 plan if—

14 (A) on August 1, 1994, the plan was a
15 self-insured health plan which—

16 (i) had been in existence and operat-
17 ing at all times during the 18-month pe-
18 riod ending on such date as a multiple em-
19 ployer welfare arrangement,

20 (ii) had an application pending with,
21 or approved by, the State insurance com-
22 missioner for a certificate of operation as
23 a health plan, and

24 (iii) covered at least 1000 lives, or

1 (B) on and after the date of enactment of
2 this Act, the plan was an experience-rated in-
3 sured health plan covering at least 1000 lives.

4 (2) DISQUALIFICATION OF CERTAIN ARRANGE-
5 MENTS.—A health plan shall not be treated as meet-
6 ing the requirements of paragraph (1)(A) if a State
7 demonstrates that—

8 (A) fraudulent or material misrepresenta-
9 tions have been made by the sponsor in the ap-
10 plication,

11 (B) the arrangement that is the subject of
12 the application, on its face, fails to meet the re-
13 quirements for a complete application, or

14 (C) a financial impairment exists with re-
15 spect to the applicant that is sufficient to dem-
16 onstrate the applicant's inability to continue its
17 operations.

18 (c) QUALIFIED ASSOCIATION.—For purposes of this
19 section, the term “qualified association” means any orga-
20 nization (or wholly-owned subsidiary thereof) which—

21 (1) is organized and maintained in good faith
22 by a trade association, an industry association, a
23 professional association, a local chamber of com-
24 merce, or public entity association,

1 (2) is organized and maintained for substantial
2 purposes other than to provide a health plan and a
3 substantial share of whose revenues do not come
4 from the sale of health plans,

5 (3) has a constitution, bylaws, or other similar
6 governing document which specifically states its pur-
7 pose,

8 (4) receives the active support of its members,

9 (5) does not have membership policies or prac-
10 tices which have the effect of screening members or
11 prospective members (or their dependents), and does
12 not otherwise limit access to any health plan main-
13 tained by it, on the basis of health status or evidence
14 (or lack of evidence) of insurability of an individual,
15 and

16 (6) has been in operation continuously during
17 the 3-year period ending August 1, 1994 and has
18 provided health coverage to its members over such
19 period.

20 (d) COORDINATION WITH SUBPART B.—The term
21 “certified association plan” shall not include a plan to
22 which subpart B applies.

23 (e) DEFINITIONS.—For purposes of this part, the
24 term “multiple employer welfare arrangement” has the
25 meaning given such term by section 3(40) of the Employee

1 Retirement Income Security Act of 1974 (as in effect be-
 2 fore the date of the enactment of the Health Reform Act).

3 **SEC. 1324. REPEAL OF ERISA PROVISIONS.**

4 (a) DEFINITION.—Paragraph (40) of section 3 of the
 5 Employee Retirement Income Security Act of 1974 (29
 6 U.S.C. 1002(40)) is repealed.

7 (b) PREEMPTION.—Paragraph (6) of section 514(b)
 8 of such Act (29 U.S.C. 1144(b)(6)) is repealed.

9 **Subpart B—Special Rule for Church and**
 10 **Multiemployer Plans**

11 **SEC. 1325. SPECIAL RULE FOR CHURCH AND MULTIEM-**
 12 **PLOYER PLANS.**

13 (a) GENERAL RULE.—For purposes of this Act, in
 14 the case of a health plan to which this section applies—

15 (1) except as otherwise provided in this part,
 16 the plan shall be required to meet all applicable re-
 17 quirements of this Act for certified health plans
 18 which are offered by large employers,

19 (2) if such plan is certified as meeting such re-
 20 quirements, such plan shall be treated as a health
 21 plan established and maintained by a large employer
 22 and individuals enrolled in such plan shall be treated
 23 as experience-rated individuals, and

24 (3) any individual eligible to enroll in the plan
 25 who does not enroll in the plan shall not be treated

1 as an experience-rated individual solely by reason of
2 being eligible to enroll in the plan.

3 (b) MODIFIED STANDARDS.—

4 (1) CERTIFYING AUTHORITY.—For purposes of
5 this Act, the Secretary of Labor shall be the appro-
6 priate certifying authority with respect to a plan to
7 which this section applies.

8 (2) SOLVENCY, AND AVAILABILITY.—Rules
9 similar to the rules of subsections (c) and (d) of sec-
10 tion 1322 shall apply to a plan to which this section
11 applies.

12 (3) ACCESS.—An employer which, pursuant to
13 a collective bargaining agreement, offers an em-
14 ployee the opportunity to enroll in a plan described
15 in subsection (c)(2) shall not be required to make
16 any other plan available to the employee.

17 (c) PLANS TO WHICH SECTION APPLIES.—This sec-
18 tion shall apply to a health plan which—

19 (1) is a church plan (as defined in section
20 414(e) of the Internal Revenue Code of 1986) which
21 covers 100 or more lives in the United States, or

22 (2) is a multiemployer plan (as defined in sec-
23 tion 3(37) of the Employee Retirement Income Se-
24 curity Act of 1974) which is maintained by a health
25 plan sponsor described in section 3(16)(B)(iii) of

1 such Act but only if such plan (or a predecessor
2 plan) as of August 1, 1994—

3 (A) offered health benefits, and

4 (B) covered at least 500 lives in the
5 United States.

6 Notwithstanding paragraph (2)(B), a multiemployer plan
7 sponsored by one or more affiliates of the same labor orga-
8 nization, or one or more affiliates of labor organizations
9 representing employees in the same industry, may be com-
10 bined to meet the threshold described in such subpara-
11 graph.

12 **PART 4—ACCESS THROUGH FEHBP**

13 **SEC. 1331. ACCESS THROUGH FEHBP PLANS.**

14 (a) IN GENERAL.—Any health plan participating in
15 the Federal Employees Health Benefits Program under
16 chapter 89 of title 5, United States Code (in this Act re-
17 ferred to as “FEHBP”), shall offer such plan to commu-
18 nity-rated individuals and small employers in community
19 rating areas served by such plan at a premium established
20 in accordance with section 1413. In the case of a plan
21 described in section 8903(1) of title 5, United States
22 Code, the requirement of this subsection shall be deemed
23 to be a requirement on the local carriers providing cov-
24 erage pursuant to an agreement with a national plan.

1 (b) LIMITATION.—A health plan may not be required
 2 to offer enrollment under subsection (a) if the Director
 3 of the Office of Personnel Management determines, based
 4 on a petition submitted by the health plan, that—

5 (1) the plan is unable to make such offering be-
 6 cause of a limitation in the capacity of the plan to
 7 deliver services or assure financial solvency; or

8 (2) the plan is not sponsored by a carrier li-
 9 censed under applicable State law.

10 The Director shall not make such a determination on the
 11 basis of any difference in the health status of Federal Gov-
 12 ernment employees and the community-rated population.

13 **Subtitle E—Standards for Reform**

14 **PART 1—ESTABLISHMENT AND APPLICATION OF** 15 **STANDARDS**

16 **SEC. 1401. CERTIFIED HEALTH PLANS.**

17 A certified health plan shall meet the applicable re-
 18 form standards established under part 2 for insured health
 19 plans and part 3 for self-insured health plans.

20 **SEC. 1402. GENERAL RULES.**

21 (a) CONSTRUCTION.—Whenever in this subtitle a re-
 22 quirement or standard is imposed on a health plan, the
 23 requirement or standard is deemed to have been imposed
 24 on the insurer or sponsor of the plan in relation to that
 25 plan.

1 (b) USE OF INTERIM, FINAL REGULATIONS.—In
 2 order to permit the timely implementation of the provi-
 3 sions of this title, the Secretary and the Secretary of
 4 Labor are each authorized to issue regulations under this
 5 title on an interim basis that become final on the date
 6 of publication, subject to change based on subsequent pub-
 7 lic comment.

8 (c) REFERENCE TO REFORM STANDARDS.—For pur-
 9 poses of this title, the term “reform standards” means the
 10 standards established and applied under this subtitle.

11 **PART 2—STANDARDS APPLICABLE TO CERTIFIED**
 12 **INSURED HEALTH PLANS**

13 **SEC. 1411. GUARANTEED ISSUE AND RENEWAL.**

14 (a) ISSUE.—

15 (1) IN GENERAL.—Except as otherwise pro-
 16 vided in this section, a certified health plan spon-
 17 sor—

18 (A) offering—

19 (i) a community-rated certified health
 20 plan, shall offer such plan to any commu-
 21 nity-rated individual applying for coverage,
 22 and

23 (ii) an experience-rated certified
 24 health plan, shall offer such plan to any

1 experience-rated individual eligible for cov-
2 erage under the plan; and

3 (B) shall offer such plan for each
4 class of enrollment described in section
5 1413(b)(2)(B)(ii).

6 (2) AVAILABILITY.—Except as provided in
7 paragraph (4), a community-rated certified health
8 plan shall be made available throughout the entire
9 community rating area in which such plan is offered,
10 including through any purchasing cooperative choos-
11 ing to offer such plan.

12 (3) APPLICATION OF CAPACITY LIMITS.—

13 (A) IN GENERAL.—Subject to subpara-
14 graph (B), a certified health plan may cease en-
15 rolling individuals under the plan if—

16 (i) the plan ceases to enroll any new
17 individuals; and

18 (ii) the applicable certifying authority
19 determines that the plan's financial or pro-
20 vider capacity to serve previously covered
21 groups or individuals (and additional indi-
22 viduals who will be expected to enroll be-
23 cause of affiliation with such previously
24 covered groups or individuals) will be im-

1 paired if such plan is required to enroll
2 other individuals.

3 (B) FAIR ENROLLMENT.—A certified
4 health plan may exercise the limitations pro-
5 vided for in subparagraph (A) only if such plan
6 provides individuals with a fair opportunity to
7 enroll in the plan, regardless of the method by
8 which such individuals seek enrollment or the
9 time during the open enrollment period at
10 which enrollment is sought.

11 (4) NETWORK PLANS.—A network plan may be
12 made available only in a service area not identical to
13 the borders of a community rating area if the State
14 determines that—

15 (A)(i) the plan has not established its serv-
16 ice area in a manner that has the effect of dis-
17 criminating against an individual or groups of
18 individuals on the basis of categories described
19 in section 1414; and

20 (ii) the service area is not smaller than a
21 county, or 3-digit zip code area;

22 (B) the service area has been approved
23 pursuant to title XIII of the Public Health
24 Service Act; and

1 (C) the network plan shall participate in
2 any risk adjustment program established for
3 each community rating area involved.

4 (b) RENEWAL.—

5 (1) IN GENERAL.—Except as provided in para-
6 graph (2), a certified health plan that is issued to
7 an individual shall be renewed at the option of the
8 individual.

9 (2) GROUNDS FOR REFUSAL TO RENEW.—

10 (A) IN GENERAL.—Except as provided in
11 subparagraph (B), a certified health plan spon-
12 sor may under no circumstances refuse to
13 renew, or for any reason terminate, a certified
14 health plan with respect to any individual, fam-
15 ily, or employer under this title.

16 (B) EXCEPTION.—Subparagraph (A) shall
17 not apply in the case of—

18 (i) nonpayment of premiums;

19 (ii) fraud on the part of the individual
20 involved;

21 (iii) misrepresentation of material
22 facts on the part of the individual relating
23 to an application for coverage or claim for
24 benefits; or

1 (iv) exit of the insurer from the mar-
2 ket if pursuant to rules established by the
3 Secretary.

4 (c) CERTAIN EXCLUDED PLANS.—The provisions of
5 this section (other than subsection (b)) and section 1451
6 (other than subsections (b)(1)(B), (b)(2), and (b)(3)),
7 shall not apply to any religious fraternal benefit society
8 in existence as of September 1993, which bears the risk
9 of providing insurance to its members, and which is an
10 organization described in section 501(c)(8) of the Internal
11 Revenue Code of 1986 which is exempt from taxation
12 under section 501(a) of such Code.

13 **SEC. 1412. ENROLLMENT.**

14 (a) IN GENERAL.—A certified health plan shall estab-
15 lish an enrollment process consistent rules established by
16 the Secretary.

17 (b) ENROLLMENT REQUIREMENTS.—The rules es-
18 tablished under subsection (a) shall provide for—

19 (1) general enrollment periods;

20 (2) special enrollment periods for individuals
21 who experience a change in their employment of
22 family situation or in their residence; and

23 (3) disenrollment for cause.

1 **SEC. 1413. RATING LIMITATIONS FOR COMMUNITY-RATED**
 2 **MARKET.**

3 (a) STANDARD PREMIUMS WITH RESPECT TO COM-
 4 MUNITY-RATED ELIGIBLE INDIVIDUALS.—Each certified
 5 health plan which covers community-rated individuals
 6 shall establish within each community rating area in which
 7 the plan is to be offered, a standard premium for individ-
 8 ual enrollment.

9 (b) UNIFORM PREMIUMS WITHIN COMMUNITY RAT-
 10 ING AREAS.—

11 (1) IN GENERAL.—Subject to paragraphs (2)
 12 and (3), the standard premium for each certified
 13 health plan shall be the same, and shall not include
 14 the administrative costs described in paragraph (3).

15 (2) APPLICATION TO ENROLLEES.—

16 (A) IN GENERAL.—The premium charged
 17 for coverage in a certified health plan which
 18 covers community-rated individuals shall be the
 19 product of—

20 (i) the standard premium (established
 21 under paragraph (1));

22 (ii) in the case of enrollment other
 23 than individual enrollment, the family ad-
 24 justment factor specified under subpara-
 25 graph (B); and

1 (iii) the age adjustment factor (speci-
2 fied under subparagraph (C)).

3 (B) FAMILY ADJUSTMENT FACTOR.—

4 (i) IN GENERAL.—The reform stand-
5 ards shall specify family adjustment fac-
6 tors that reflect the relative actuarial costs
7 of benefit packages based on family classes
8 of enrollment (as compared with such costs
9 for individual enrollment).

10 (ii) CLASSES OF ENROLLMENT.—

11 (I) IN GENERAL.—In this Act,
12 each of the following is a separate
13 class of family enrollment:

14 (aa) Coverage only of an in-
15 dividual (referred to in this Act
16 as the “individual” enrollment or
17 class of enrollment).

18 (bb) Coverage of a married
19 couple without children (referred
20 to in this Act as the “couple-
21 only” enrollment or class of en-
22 rollment).

23 (cc) Coverage of an unmar-
24 ried individual and one or more
25 children (referred to in this Act

as the “single parent” enrollment
or class of enrollment).

(dd) Coverage of a married
couple and one or more children
(referred to in this Act as the
“dual parent” enrollment or class
of enrollment).

(II) REFERENCES TO FAMILY
AND COUPLE CLASSES OF ENROLL-
MENT.—In this Act:

(aa) FAMILY.—The terms
“family enrollment” and “family
class of enrollment”, refer to en-
rollment in a class of enrollment
described in item (bb), (cc), or
(dd) of subclause (I).

(bb) COUPLE.—The term
“couple class of enrollment” re-
fers to enrollment in a class of
enrollment described in item (bb)
or (dd) of subclause (I).

(III) SPOUSE; MARRIED; COU-
PLE.—

(aa) IN GENERAL.—In this
Act, the terms “spouse” and

1 “married” mean, with respect to
2 a person, another individual who
3 is the spouse of the person or
4 married to the person, as deter-
5 mined under applicable State
6 law.

7 (bb) COUPLE.—The term
8 “couple” means an individual
9 and the individual’s spouse.

10 (C) AGE ADJUSTMENT FACTOR.—

11 (i) IN GENERAL.—The Secretary, in
12 consultation with the NAIC, shall specify
13 uniform age categories and maximum rat-
14 ing increments for age adjustment factors
15 that reflect the relative actuarial costs of
16 benefit packages among enrollees. For in-
17 dividuals who have attained age 18 but not
18 age 65, the highest age adjustment factor
19 may not exceed twice the lowest age ad-
20 justment factor.

21 (ii) PHASE-IN PERIOD.—The Sec-
22 retary, in consultation with the NAIC,
23 shall establish a schedule for the phase-in
24 of age-adjusted community rates so as to

1 minimize disruption of the insurance mar-
2 ket.

3 (3) ADMINISTRATIVE SAVINGS.—Nothing in
4 this section shall be construed as preventing a pur-
5 chasing cooperative from negotiating a unique pre-
6 mium with a certified health plan that reflects ad-
7 ministrative and other sources of savings.

8 **SEC. 1414. NONDISCRIMINATION BASED ON HEALTH STA-**
9 **TUS.**

10 Except as otherwise provided in this Act, a certified
11 health plan may not deny, limit, or condition the coverage
12 under (or benefits of) the plan for any reason, including
13 but not limited to, health status, medical condition, claims
14 experience, receipt of health care, medical history, antici-
15 pated need for health care, disability, or lack of evidence
16 of insurability, of an individual.

17 **SEC. 1415. BENEFITS OFFERED.**

18 A certified health plan shall offer to all enrollees in
19 the plan the comprehensive benefits established under sub-
20 title B.

21 **SEC. 1416. REQUIREMENTS OF SUPPLEMENTALS.**

22 A certified health plan sponsor may only offer bene-
23 fits that are not covered benefits, or a reduction in cost
24 sharing below the cost sharing specified under section
25 1101(h), if—

1 (1) such additional coverage is offered and
2 priced separately from the comprehensive benefits
3 package offered by such plan;

4 (2) the purchase of the certified health plan is
5 not conditioned upon the purchase of such additional
6 coverage;

7 (3) coverage of such additional benefits is also
8 offered to individuals who are not enrolled in the
9 certified health plan; and

10 (4) the cost sharing reduction is offered only to
11 individuals enrolled in the certified health plan by
12 such plan for a price which includes any expected in-
13 crease in utilization resulting from the purchase of
14 such cost sharing reduction.

15 **SEC. 1417. RISK ADJUSTMENT.**

16 (a) IN GENERAL.—Each community-rated certified
17 health plan shall participate in a risk adjustment program
18 of the State in accordance with subsection (b).

19 (b) ESTABLISHMENT OF STANDARDS FOR RISK AD-
20 JUSTMENT PROGRAMS.—

21 (1) IN GENERAL.—The Secretary shall develop
22 standards under paragraph (2) for participating
23 States to provide risk adjustment programs under
24 section 1207 for participation by certified health
25 plans.

1 (2) RISK ADJUSTMENT PROGRAM.—The stand-
2 ards developed by the Secretary under this para-
3 graph shall include a risk adjustment program
4 which—

5 (A) assures that payments to community-
6 rated certified health plans reflect the expected
7 relative utilization and expenditures for health
8 care services by each plan’s enrollees compared
9 to the average utilization and expenditures for
10 community-rated individuals; and

11 (B) protects plans that enroll a dispropor-
12 tionate share of such individuals with respect to
13 whom expected utilization of health care serv-
14 ices and expected health care expenditures for
15 such services are greater than the average utili-
16 zation and expenditures for such eligible indi-
17 viduals.

18 **SEC. 1418. FINANCIAL REQUIREMENTS.**

19 Each sponsor offering a community-rated certified
20 health plan shall meet financial solvency requirements to
21 assure protection of enrollees with respect to potential in-
22 solvency. The Secretary, in consultation with the NAIC,
23 shall establish such standards by regulation.

1 **SEC. 1419. COLLECTION AND PROVISION OF STANDARD-**
2 **IZED INFORMATION.**

3 Each certified health plan that provides coverage for
4 individuals residing in a State shall submit to the State
5 and, upon request, to community-rated individuals, infor-
6 mation regarding—

7 (1) certification status of the plan;

8 (2) benefits offered under the plan;

9 (3) premiums, cost-sharing, and administrative
10 charges under the plan;

11 (4) risk and referral arrangements under the
12 plan;

13 (5) the number, distribution, and variety of
14 health care providers used under the plan and the
15 availability of such providers;

16 (6) the enrollee complaint and appeals process
17 used under the plan;

18 (7) the rights and responsibilities of plan enroll-
19 ees; and

20 (8) other information determined appropriate
21 by the Secretary or the State.

22 **SEC. 1420. QUALITY IMPROVEMENT AND ASSURANCE.**

23 (a) IN GENERAL.—Each certified health plan shall
24 establish procedures, including ongoing quality improve-
25 ment procedures, to ensure that the health care services
26 provided to enrollees under the plan will be provided under

1 reasonable standards of quality of care consistent with
2 prevailing professionally recognized standards of medical
3 practice.

4 (b) INTERNAL QUALITY ASSURANCE PROGRAM.—
5 Each certified health plan shall establish, and commu-
6 nicate to its enrollees and its providers, an ongoing inter-
7 nal program, including periodic reporting, to monitor and
8 evaluate the quality and cost effectiveness of its health
9 care services, pursuant to standards established by the
10 Secretary.

11 (c) UTILIZATION MANAGEMENT PROTOCOLS.—The
12 utilization review and management activities of each cer-
13 tified health plan, provided either directly or through con-
14 tract, shall meet the following standards as defined by the
15 Secretary:

16 (1) PERSONNEL.—All review determinations
17 shall be made by licensed, certified, or otherwise
18 credentialed health professionals who are qualified to
19 review utilization of the treatment being sought.

20 (2) REVIEW PROCESS.—Each certified health
21 plan shall base utilization management on current
22 scientific knowledge, stress the efficient delivery of
23 health care and outcomes, rely primarily on evaluat-
24 ing and comparing practice patterns rather than
25 routine case-by-case review, be consistent and timely

1 in application, and have a process for making review
2 determinations for urgent and emergency care 24
3 hours a day.

4 (3) NO FINANCIAL INCENTIVES.—Utilization
5 management by each certified health plan may not
6 create financial incentives for reviewers to reduce or
7 limit medically necessary or appropriate services.

8 (4) CONSUMER DISCLOSURE.—Each certified
9 health plan shall disclose, upon request, to enrollees
10 (and prospective enrollees) and to participating pro-
11 viders (and prospective providers) the utilization re-
12 view protocols and the type of financial arrange-
13 ments, if any, used by the plan for controlling utili-
14 zation and costs, while protecting proprietary busi-
15 ness information to the extent specified by the Sec-
16 retary.

17 (d) PHYSICIAN INCENTIVE PLANS.—A certified
18 health plan may not operate a physician incentive plan un-
19 less such incentive plan meets the requirements of section
20 1876(i)(8)(A) of the Social Security Act (42 U.S.C.
21 1395mm(i)(8)(A)).

22 (e) CREDENTIALING.—Each certified health plan
23 shall—

24 (1) verify the credentials of participating physi-
25 cians and practitioners; and

1 (2) ensure that participating providers and fa-
2 cilities are appropriately accredited, certified, and li-
3 censed.

4 **SEC. 1421. PATIENT PROTECTIONS AND PROVIDER SELEC-**
5 **TION.**

6 (a) INFORMATION REGARDING A PATIENT'S RIGHT
7 TO SELF-DETERMINATION IN HEALTH CARE SERV-
8 ICES.—Each certified health plan shall be considered to
9 be an eligible organization under title XVIII of the Social
10 Security Act for purposes of applying the rules under sec-
11 tion 1866(f) of such Act (42 U.S.C. 1395cc(f)).

12 (b) GATEKEEPER.—With respect to each network
13 plan that utilizes a gatekeeper or similar process to ap-
14 prove network items and services, such plan shall ensure
15 that such gatekeeper or process does not create an undue
16 burden for enrollees with complex or chronic health condi-
17 tions and shall ensure access to relevant specialists for the
18 continued care of such enrollees when medically indicated.
19 In cases of a patient with a severe, complex, or chronic
20 health condition, such plan shall determine, in conjunction
21 with the enrollee and the enrollee's primary care provider,
22 whether it is medically necessary or appropriate to use a
23 specialist or a care coordinator from an interdisciplinary
24 team as the gatekeeper or in the health care approval
25 process.

1 (c) CONFIDENTIALITY OF PATIENT RECORDS.—Each
2 certified health plan shall have explicit procedures to pro-
3 tect the confidentiality of individual patient information.

4 (d) MARKETING.—A sponsor of a certified health
5 plan may not engage in selective marketing that would
6 have the effect of avoiding high-risk subscribers within a
7 community-rating area. Marketing materials may not con-
8 tain false or materially misleading information.

9 (e) NO PATIENT LIABILITY FOR UNPAID PLAN OBLI-
10 GATIONS.—An individual enrolled in a certified health
11 plan shall not be liable to any health care provider or prac-
12 titioner with respect to the provision of health services cov-
13 ered by the plan in excess of the amount for which the
14 individual would have been liable had the health plan made
15 payments to providers in a timely manner.

16 (f) REMEDIES AND ENFORCEMENT.—

17 (1) IN GENERAL.—Each certified health plan
18 shall comply with the applicable remedies and en-
19 forcement requirements.

20 (2) GRIEVANCE PROCESS.—Each certified
21 health plan shall establish a grievance process for
22 enrollees dissatisfied with matters other than the de-
23 nial of payment or provision of benefits by the plan.

1 (g) ENROLLMENT.—A certified health plan may not
2 knowingly accept the enrollment of an individual who is
3 enrolled in another certified health plan.

4 (h) PROVIDER SELECTION.—

5 (1) IN GENERAL.—In selecting among providers
6 of health services for membership in a provider net-
7 work, or in establishing the terms and conditions of
8 such membership, a certified health plan may not
9 engage in any practice that discriminates against a
10 provider based on the actual or anticipated health
11 status of the patients of the provider.

12 (2) ADDITIONAL REQUIREMENTS.—No health
13 plan may discriminate on the basis of the provider's
14 status as a member of a health care profession for
15 the purposes of selecting among providers of health
16 services for participation in a provider network, pro-
17 vided that the State authorizes members of that pro-
18 fession to render the services in question and that
19 such services are covered in the comprehensive bene-
20 fits package described in subtitle B.

21 (3) NUMBER AND TYPE.—Nothing in this sub-
22 section shall—

23 (A) prevent a certified health plan sponsor
24 from matching the number and type of health

1 care providers to the needs of the plan mem-
 2 bers; or

3 (B) establish any other measure designed
 4 to maintain quality or to control costs.

5 (i) PHYSICIAN PARTICIPATION.—Each certified
 6 health plan shall establish mechanisms through which phy-
 7 sicians have input into matters affecting patient care and
 8 through which patients have the ability to choose any pri-
 9 mary care physician from among participating providers.

10 **SEC. 1422. ARRANGEMENTS WITH ESSENTIAL COMMUNITY**
 11 **PROVIDERS.**

12 (a) CERTIFICATION.—The Secretary shall certify as
 13 an essential community provider the following providers
 14 and organizations:

15 (1) Covered entities as defined in section
 16 340B(a)(4) of the Public Health Service Act (42
 17 U.S.C. 256b(a)(4)), and comparable nonprofit hos-
 18 pitals, except that subsections (a)(4)(L)(iii) and
 19 (a)(7) of such section shall not apply.

20 (2) A Medicare dependent small rural hospital
 21 under section 1886(d)(8)(iii) of the Social Security
 22 Act.

23 (3) Children's hospitals meeting comparable cri-
 24 teria determined appropriate by the Secretary.

1 (4) Public and private, nonprofit mental health
2 and substance abuse providers receiving funds under
3 title V or XIX of the Public Health Service Act.

4 (5) Runaway homeless youth centers or transi-
5 tional living programs for homeless youth providing
6 health services under the Runaway Homeless Youth
7 Act of 1974 (42 U.S.C. 5701 et seq.).

8 (6) Public or nonprofit maternal and child
9 health providers that receive funding under title V of
10 the Social Security Act.

11 (7) Rural health clinics as defined under section
12 1861(aa)(2) of the Social Security Act.

13 (8) School health services centers under title III
14 of this Act.

15 (9) Nonprofit hospitals with a minimum of 200
16 beds, located in urban areas where—

17 (A) the cumulative total of its services pro-
18 vided to individuals who are entitled to benefits
19 under title XVIII of the Social Security Act or
20 under a State plan under title XIX of such Act
21 equals a minimum of 65 percent; and

22 (B) a minimum of 20 percent of its serv-
23 ices are provided to individuals eligible for as-
24 sistance under such title XIX.

1 (b) REQUIREMENTS RELATING TO ESSENTIAL COM-
2 MUNITY PROVIDERS.—

3 (1) IN GENERAL.—Each health plan shall, with
4 respect to each electing essential community pro-
5 vider (as defined in paragraph (5), other than a pro-
6 vider of school health services) located within the
7 plan's service area, either—

8 (A) enter into a written provider participa-
9 tion agreement (described in paragraph (3))
10 with the provider; or

11 (B) enter into a written agreement under
12 which the plan shall make payment to the pro-
13 vider in accordance with paragraph (4).

14 The requirements of this paragraph shall not apply
15 to a health plan with respect to any essential com-
16 munity provider for which a demonstration is made
17 pursuant to paragraph (2).

18 (2) WAIVERS.—Effective one year after the
19 date on which a State becomes a participating State,
20 the Secretary shall grant a waiver of the require-
21 ments of paragraph (1) to any health plan that dem-
22 onstrates that it has the capacity to provide services
23 to plan enrollees residing in the area served by an
24 essential community provider that are reasonably
25 equivalent to the services provided by the essential

1 community provider in terms of the scope of services
2 and convenience. Any such waiver shall not become
3 effective until the plan year following the succeeding
4 open enrollment period. Any health plan receiving
5 such a waiver shall notify the essential community
6 provider with respect to which such a waiver has
7 been granted and enrollees of the plan not less than
8 60 days prior to the commencement of such enroll-
9 ment period.

10 (3) PARTICIPATION AGREEMENT.—A participa-
11 tion agreement between a health plan and an elect-
12 ing essential community provider under this para-
13 graph shall provide that the health plan agrees to
14 treat the provider in accordance with terms and con-
15 ditions at least as favorable as those that are appli-
16 cable to other providers participating in the health
17 plan with respect to each of the following:

18 (A) The scope of services for which pay-
19 ment is made by the plan to the provider.

20 (B) The rate of payment for covered care
21 and services.

22 (C) The availability of financial incentives
23 to participating providers.

24 (D) Limitations on financial risk provided
25 to other participating providers.

1 (E) Assignment of enrollees to participat-
2 ing providers.

3 (F) Access by the provider's patients to
4 providers in medical specialties or subspecialties
5 participating in the plan.

6 (4) PAYMENTS FOR PROVIDERS WITHOUT PAR-
7 TICIPATION AGREEMENTS.—

8 (A) IN GENERAL.—Payment in accordance
9 with this paragraph is payment based on pay-
10 ment methodologies and rates used under the
11 applicable Medicare payment methodology and
12 rates (or the most closely applicable methodol-
13 ogy under such program as the Secretary of
14 Health and Human Services specifies in regula-
15 tions).

16 (B) NO APPLICATION OF GATE-KEEPER
17 LIMITATIONS.—Payment in accordance with
18 this paragraph may be subject to utilization re-
19 view, but may not be subject to otherwise appli-
20 cable gate-keeper requirements under the plan.

21 (5) ELECTION.—

22 (A) IN GENERAL.—In this section, the
23 term “electing essential community provider”
24 means, with respect to a health plan, an essen-

1 tial community provider that elects this section
2 to apply to the health plan.

3 (B) FORM OF ELECTION.—An election
4 under this paragraph shall be made in a form
5 and manner specified by the Secretary, and
6 shall include notice to the health plan involved.
7 Such an election may be made annually with re-
8 spect to a health plan, except that the plan and
9 provider may agree to make such an election on
10 a more frequent basis.

11 (c) RECOMMENDATION ON CONTINUATION OF RE-
12 QUIREMENT.—

13 (1) STUDIES.—In order to prepare rec-
14 ommendations under paragraph (2), the Secretary
15 shall conduct studies regarding essential community
16 providers, including studies that assess—

17 (A) the definition of essential community
18 provider,

19 (B) the sufficiency of the funding levels for
20 providers, including rules for federally qualified
21 health centers, for both covered and uncovered
22 benefits under this Act,

23 (C) the effects of contracting requirements
24 relating to such providers on such providers,
25 health plans, and enrollees,

1 (D) the impact of the payment rules for
2 such providers, and

3 (E) the impact of national health reform
4 on such providers.

5 (2) RECOMMENDATIONS TO CONGRESS.—The
6 Secretary shall submit to Congress, by not later
7 than March 1, 2001, specific recommendations re-
8 specting whether, and to what extent, subsection (b)
9 should continue to apply to some or all essential
10 community providers. Such recommendations may
11 include a description of the particular types of such
12 providers and circumstances under which such sec-
13 tion should continue to apply.

14 **SEC. 1423. ACCESS TO SPECIALIZED SERVICES.**

15 (a) IN GENERAL.—Each certified health plan shall
16 have within the plan's network, or have such other ar-
17 rangements with, a sufficient number, distribution, and
18 variety of providers of specialized services to assure that
19 such services are available and accessible to adults, in-
20 fants, children, and persons with disabilities. With respect
21 to children such specialized care shall be in pediatrics.

22 (b) ELIGIBLE CENTERS OF SPECIALIZED TREAT-
23 MENT EXPERTISE.—

24 (1) IN GENERAL.—Each network plan shall
25 demonstrate that adults, children, and individuals

1 with disabilities have access to specialized treatment
2 expertise when medically indicated by meeting eval-
3 uation criteria established by the Secretary. In es-
4 tablishing such criteria, the Secretary may consider
5 a process by which a network plan could be deemed
6 to meet such evaluation criteria if such plan dem-
7 onstrates referrals to designated centers of special-
8 ized care when medically necessary or appropriate
9 and informs enrollees of the availability of referral
10 care.

11 (2) ELIGIBLE CENTERS.—The Secretary shall
12 establish criteria for designating centers of special-
13 ized care and shall designate eligible centers based
14 on such criteria. The criteria shall include require-
15 ments for staff credentials and experience, and re-
16 quirements for measured outcomes in the diagnosis
17 and treatment of patients. The Secretary shall de-
18 velop additional criteria for outcomes of specialized
19 treatment as research findings become available. To
20 be designated as a center of specialized care, a cen-
21 ter shall—

22 (A) attract patients from outside the cen-
23 ter's local geographic region, from across the
24 State or the United States; and

1 (B) either sponsor, participate in, or have
2 medical staff who participate in peer-reviewed
3 research.

4 (3) LIMITATION.—A State may not establish
5 rules or policies that require or encourage network
6 plans to give preference to centers of specialized
7 treatment expertise within the State or within the
8 community rating area. A health plan shall not pro-
9 hibit an academic health center, teaching hospital, or
10 other center for specialized care with which it con-
11 tracts from contracting with one or more other
12 plans.

13 (4) SPECIALIZED TREATMENT EXPERTISE.—
14 For purposes of this subsection, the term “special-
15 ized treatment expertise”, with respect to the treat-
16 ment of a health condition by an eligible center,
17 means expertise in diagnosing and treating unusual
18 diseases or conditions, diagnosing and treating dis-
19 eases or conditions which are unusually difficult to
20 diagnose or treat, and providing other specialized
21 health care.

22 (c) EVALUATION CRITERIA FOR SPECIALIZED SERV-
23 ICES STANDARDS.—A certified health plan may choose to
24 provide specialized services within a provider network if
25 such provision meets the requirements of this section.

1 **SEC. 1424. COMMUNITY RATING AREA CAPACITY.**

2 Each certified health plan shall have the capacity
3 within the plan's network, or through arrangements with
4 a sufficient number, distribution, and variety of providers,
5 to deliver the comprehensive benefits required under sub-
6 title B throughout the community rating area (designated
7 under section 1203) in which such plan is offered. Services
8 shall be provided with reasonable promptness and acces-
9 sibility, in a manner which assures continuity, and in a
10 manner which appropriately serves the diverse needs of
11 the population.

12 **SEC. 1425. OUT-OF-AREA COVERAGE.**

13 Each certified health plan shall provide emergency
14 out-of-area and out-of-plan coverage for enrollees of the
15 plan and urgent out-of-area coverage.

16 **PART 3—STANDARDS APPLICABLE TO CERTIFIED**
17 **SELF-INSURED HEALTH PLANS**

18 **SEC. 1431. STANDARDS APPLICABLE TO CERTIFIED SELF-**
19 **INSURED HEALTH PLANS.**

20 (a) IN GENERAL.—Subject to subsection (b), the re-
21 quirements applicable to certified self-insured health plans
22 are the requirements specified in the following provisions
23 (as modified in regulations promulgated by the Secretary
24 of Labor to make such provisions applicable to self-insured
25 plans):

1 (1) Section 1411, except that such subsections
2 (a) and (b) shall be applied (for purposes of this
3 subsection) only with respect to employees of the
4 employer sponsor or members of the family of such
5 employees.

6 (2) Sections 1412 through 1425, except that
7 sections 1413(a), 1416, 1417, and 1418 shall not
8 apply.

9 (b) COLLECTIVE BARGAINING EXCEPTION.—Para-
10 graph (1) of subsection (a) shall not apply to a certified
11 self-insured health plan sponsor that is providing benefits
12 pursuant to a collective bargaining agreement.

13 (c) FINANCIAL SOLVENCY.—Each certified self-in-
14 sured health plan shall meet the solvency, reserve, and
15 stop-loss requirements established by the Secretary of
16 Labor under section 1501.

17 (d) MANAGEMENT OF FUNDS.—

18 (1) MANAGEMENT OF FUNDS.—A certified self-
19 insured health plan sponsor shall, in the manage-
20 ment of the plan's funds, be subject to the applicable
21 fiduciary requirements of part 4 of subtitle B of title
22 I of the Employee Retirement Income Security Act
23 of 1974, together with the applicable enforcement
24 provisions of part 5 of subtitle B of title I of such
25 Act.

1 (2) MANAGEMENT OF FINANCES AND RECORDS;
 2 ACCOUNTING SYSTEM.—A certified self-insured
 3 health plan sponsor shall comply with standards re-
 4 lating to the management of finances and records
 5 and accounting systems as the Secretary of Labor
 6 shall specify.

7 (e) ADDITIONAL STANDARDS.—In addition to the re-
 8 quirements applicable to certified self-insured health plans
 9 under subsection (a), the Secretary of Labor shall estab-
 10 lish standards to ensure that such health plans and in-
 11 sured, experience-rated health plans—

12 (1) do not vary premiums for any reason de-
 13 scribed in section 1414(a);

14 (2) do not discriminate on a basis described in
 15 section 1203(e) (relating to geographic discrimina-
 16 tion); and

17 (3) provide information to employees of the em-
 18 ployer sponsor of the plans offered.

19 **PART 4—PREEMPTION OF CERTAIN STATE LAWS**

20 **SEC. 1441. PREEMPTION FROM STATE BENEFIT MANDATES.**

21 Effective as of January 1, 1997, no State shall estab-
 22 lish or enforce any law or regulation that—

23 (1) requires the offering, as part of a certified
 24 health plan, of any services, category of care, or
 25 services of any class or type of provider that is dif-

1 ferent from the benefit categories specified under
2 this Act; or

3 (2) requires a right of conversion from a group
4 health plan that is a certified health plan to an indi-
5 vidual certified health plan.

6 **SEC. 1442. PREEMPTION OF STATE LAW RESTRICTIONS ON**
7 **CERTIFIED HEALTH PLANS.**

8 Effective as of January 1, 1997—

9 (1) a State may not prohibit or limit a certified
10 health plan from including incentives for enrollees to
11 use the services of participating providers;

12 (2) a State may not prohibit or limit such plans
13 from limiting coverage of services to those provided
14 by a participating provider;

15 (3) a State may not prohibit or limit the nego-
16 tiation of rates and forms of payments for providers
17 under such plans;

18 (4) a State may not prohibit or limit such plans
19 from limiting the number of participating providers;

20 (5) a State may not prohibit or limit such plans
21 from requiring that services be provided (or author-
22 ized) by a practitioner selected by the enrollee from
23 a list of available participating providers;

24 (6) a State may not prohibit or limit the cor-
25 porate practice of medicine;

1 (7) a State may not regulate utilization man-
 2 agement and review programs of any health plan to
 3 the extent not provided by this title;

4 (8) a State may not prohibit or limit a health
 5 plan from using single source suppliers for pharmacy
 6 services, non-serviced medical equipment, and other
 7 supplies and services; and

8 (9) a State may not prohibit a certified health
 9 plan, including a Federally qualified health mainte-
 10 nance organization, from offering a point of service
 11 option.

12 **PART 5—INTERIM STANDARDS**

13 **SEC. 1451. APPLICATION OF INTERIM STANDARDS.**

14 (a) IN GENERAL.—During the interim standards ap-
 15 plication period, a health plan sponsor may only offer a
 16 health plan in a State if such plan meets the standards
 17 specified in subsections (b) and (c).

18 (b) SPECIFIED STANDARDS.—

19 (1) GUARANTEED ISSUE AND NONDISCRIMINA-
 20 TION.—The standards specified in—

21 (A) section 1411(a), and

22 (B) section 1414.

23 (2) RENEWAL.—The standards specified in sec-
 24 tion 1411(b).

1 (3) COVERAGE.—A self-insured health plan may
2 not reduce or limit coverage of any condition or
3 course of treatment that is expected to cost not less
4 than \$5,000 during any 12-month period.

5 (c) TREATMENT OF PREEXISTING CONDITION EX-
6 CLUSIONS PRIOR TO UNIVERSAL COVERAGE.—

7 (1) IN GENERAL.—Notwithstanding section
8 1414, prior to the achievement of universal coverage,
9 a certified health plan may impose a limitation or
10 exclusion of benefits relating to treatment of a con-
11 dition based on the fact that the condition preexisted
12 the effective date of the plan with respect to an indi-
13 vidual only if—

14 (A) the condition was diagnosed or treated
15 during the 3-month period ending on the day
16 before the date of enrollment under the plan;

17 (B) the limitation or exclusion extends for
18 a period not more than 6 months after the date
19 of enrollment under the plan;

20 (C) the limitation or exclusion does not
21 apply to an individual who, as of the date of
22 birth, was covered under the plan; or

23 (D) the limitation or exclusion does not
24 apply to pregnancy.

1 (2) CREDITING OF PREVIOUS COVERAGE.—A
2 certified health plan shall provide that if an individ-
3 ual under such plan is in a period of continuous cov-
4 erage as of the date of enrollment under such plan,
5 any period of exclusion of coverage with respect to
6 a preexisting condition shall be reduced by 1 month
7 for each month in the period of continuous coverage.

8 (3) DEFINITIONS.—As used in this subsection:

9 (A) PERIOD OF CONTINUOUS COVERAGE.—
10 The term “period of continuous coverage”
11 means the period beginning on the date an indi-
12 vidual is enrolled under a health plan or health
13 care program which provides benefits similar to
14 those provided by the certified health plan in
15 which the individual is seeking to enroll with re-
16 spect to coverage of a preexisting condition and
17 ends on the date the individual is not so en-
18 rolled for a continuous period of more than 3
19 months.

20 (B) PREEXISTING CONDITION.—The term
21 “preexisting condition” means, with respect to
22 coverage under a certified health plan, a condi-
23 tion which was diagnosed, or which was treated,
24 within the 3-month period ending on the day

1 before the date of enrollment (without regard to
2 any waiting period).

3 (d) INTERIM STANDARDS APPLICATION PERIODS.—

4 The interim standards application period is—

5 (1) in the case of the standard specified in sub-
6 section (b) and (c), on or after January 1, 1996,
7 and before the State becomes a participating State;
8 and

9 (2) in the case of the standard specified in sub-
10 section (b)(3), on or after the date of the enactment
11 of this Act, and before January 1, 1997.

12 (d) PREEMPTION.—The requirements of this section
13 do not preempt any State law unless State law directly
14 conflicts with such requirements. The provision of addi-
15 tional protections under State law shall not be considered
16 to directly conflict with such requirements. The Secretary
17 may issue letter determinations with respect to whether
18 this section preempts a provision of State law.

19 (e) CONSTRUCTION.—The provisions of this section
20 shall be construed in a manner that assures, to the great-
21 est extent practicable, continuity of health benefits under
22 health plans in effect on the effective date of this Act.

23 (f) SPECIAL RULES FOR ACQUISITIONS AND TRANS-
24 FERS.—The Secretary may issue regulations regarding the
25 application of this section in the case of health plans (or

1 groups of such plans) which are transferred from one
2 health plan sponsor to another sponsor through assump-
3 tion, acquisition, or otherwise.

4 **Subtitle F—Federal** 5 **Responsibilities**

6 **PART 1—ESTABLISHMENT OF FEDERAL STAND-** 7 **ARDS FOR CERTIFIED INSURED HEALTH** 8 **PLANS**

9 **SEC. 1500. ESTABLISHMENT.**

10 The Secretary, in consultation with the NAIC and
11 other qualified experts, shall develop and publish the
12 standards specified in part 2 of subtitle E by not later
13 than June 1, 1996.

14 **PART 2—CERTIFICATION OF SELF-INSURED** 15 **HEALTH PLANS**

16 **SEC. 1501. ESTABLISHMENT AND CERTIFICATION OF** 17 **STANDARDS APPLICABLE TO SELF-INSURED** 18 **CERTIFIED HEALTH PLANS.**

19 (a) ESTABLISHMENT OF STANDARDS BY SECRETARY
20 OF LABOR.—The Secretary of Labor, in consultation with
21 the Secretary, shall develop and publish standards applica-
22 ble to certified self-insured health plans relating to the re-
23 quirements specified in part 3 of subtitle E. The Secretary
24 shall develop and publish such standards by not later than
25 June 1, 1996.

1 (b) CERTIFICATION OF HEALTH PLANS.—In the case
 2 of self-insured health plans, the Secretary of Labor shall
 3 provide for the certification of self-insured health plans as
 4 certified health plans.

5 (c) FINANCIAL STANDARDS.—The Secretary of
 6 Labor shall develop, by not later than January 1, 1996,
 7 standards for the solvency, reserve, and stop-loss require-
 8 ments for certified self-insured health plans and for quali-
 9 fied association plans.

10 **SEC. 1502. CORRECTIVE ACTIONS FOR SELF-INSURED**
 11 **HEALTH PLANS.**

12 (a) IN GENERAL.—The Secretary of Labor shall by
 13 regulation establish procedures for the filing and imple-
 14 mentation of corrective action plans in any case in which
 15 such Secretary or a self-insured plan sponsor determines
 16 that a self-insured plan has failed to meet the require-
 17 ments of this Act, or expects such a failure.

18 (b) DISQUALIFIED OR TERMINATION OF PLAN.—

19 (1) IN GENERAL.—In any case in which the
 20 plan sponsor of a self-insured health plan determines
 21 that there is reason to believe that the plan will
 22 cease to be a certified self-insured health plan or will
 23 terminate, the plan sponsor shall so inform the Sec-
 24 retary of Labor, shall develop a plan for winding up
 25 the affairs of the plan in connection with such dis-

1 qualification or termination in a manner which will
2 result in timely payment of all benefits for which the
3 plan is obligated, and shall submit such plan in writ-
4 ing to such Secretary. Actions required under this
5 subparagraph shall be taken in such form and man-
6 ner as may be prescribed in regulations by such Sec-
7 retary.

8 (2) ACTIONS REQUIRED IN CONNECTION WITH
9 DISQUALIFICATION OR TERMINATION.—

10 (A) ACTIONS BY PLAN SPONSOR.—Upon a
11 determination by the Secretary of Labor that a
12 corrective action plan has not been implemented
13 or that such a plan cannot reasonably be ex-
14 pected to bring the health plan into compliance
15 with this Act, the plan sponsor shall, at the di-
16 rection of such Secretary, terminate the plan
17 and, in the course of the termination, take such
18 actions as such Secretary may require as nec-
19 essary to ensure timely payment of all benefits
20 for which the plan is obligated.

21 (B) ACTIONS BY LARGE EMPLOYER.—
22 Upon a determination by the Secretary of
23 Labor under subparagraph (A), the large em-
24 ployer shall provide for such contingency cov-
25 erage for all employees of the employer in ac-

1 cordance with regulations which shall be pre-
2 scribed in regulations of such Secretary.

3 **SEC. 1503. ERISA APPLICABILITY TO SELF-INSURED**
4 **HEALTH PLANS.**

5 (a) IN GENERAL.—Part 1 of subtitle B of title I of
6 the Employee Retirement Income Security Act of 1974 is
7 amended—

8 (1) in the heading for section 110, by adding
9 “BY PENSION PLANS” at the end;

10 (2) by redesignating section 111 as section 112;
11 and

12 (3) by inserting after section 110 the following
13 new section:

14 “SPECIAL RULES FOR GROUP HEALTH PLANS

15 “SEC. 111. (a) IN GENERAL.—The Secretary may by
16 regulation provide special rules for the application of this
17 part to group health plans which are consistent with the
18 purposes of the Affordable Health Care for All Americans
19 Act and which take into account the special needs of par-
20 ticipants, beneficiaries, and health care providers under
21 such plans.

22 “(b) ADDITIONAL REQUIREMENTS.—Such special
23 rules may include rules providing for reporting and disclo-
24 sure to the Secretary and to participants and beneficiaries
25 of additional information or at additional times with re-
26 spect to group health plans to which this part applies

1 under section 4(c)(2), if such reporting and disclosure
 2 would be comparable to and consistent with similar re-
 3 quirements applicable under the Health Reform Act with
 4 respect to community-rated health plans and applicable
 5 regulations of the Secretary of Health and Human Serv-
 6 ices prescribed thereunder.”.

7 (b) CLERICAL AMENDMENT.—The table of contents
 8 in section 1 of such Act is amended by striking the items
 9 relating to sections 110 and 111 and inserting the follow-
 10 ing new items:

“Sec. 110. Alternative methods of compliance by pension plans.

“Sec. 111. Special rules for group health plans.

“Sec. 112. Repeal and effective date.”.

11 **PART 3—OTHER RESPONSIBILITIES**

12 **SEC. 1521. FEDERAL ROLE IN THE CASE OF A DEFAULT BY** 13 **A STATE.**

14 If a State fails to become a participating State under
 15 section 1200 or, having become a participating State, the
 16 State fails to continue to meet the requirements of such
 17 section, the Secretary shall, after notice and opportunity
 18 for correction, impose intermediate sanctions, order cor-
 19 rective actions, and may, if necessary to fulfill the pur-
 20 poses of this Act, carry out activities under this Act in
 21 the same manner as a participating State would carry out
 22 such activities.

1 **SEC. 1522. RULES DETERMINING SEPARATE EMPLOYER**
2 **STATUS.**

3 Under rules of the Secretary, employers that are re-
4 lated (as defined under such rules) shall be treated under
5 this Act as a single employer if a reason for their separa-
6 tion relates to the health risk characteristics of eligible em-
7 ployees of such employers.

8 **SEC. 1523. WORKPLACE WELLNESS PROGRAM.**

9 (a) IN GENERAL.—The Secretary shall develop cer-
10 tification criteria for workplace wellness programs.

11 (b) APPLICATION OF SECTION.—Any health plan
12 may offer a uniform premium discount, not to exceed 10
13 percent, to employers maintaining certified workplace
14 wellness programs.

15 **PART 4—COLLECTIVE BARGAINING DISPUTE**
16 **RESOLUTION**

17 **SEC. 1531. FINDINGS AND PURPOSE.**

18 (a) FINDING.—Congress finds that—

19 (1) consistent with the intention of this Act to
20 eliminate waste and inefficiency in the health care
21 industry, it is important to avoid costly and disrupt-
22 tive labor disputes; and

23 (2) such disputes are particularly likely to take
24 place during the period of transition to a restruc-
25 tured health care delivery system because of disrupt-

1 tions to established employment relationships result-
2 ing from that restructuring.

3 (b) PURPOSE.—It is the purpose of this part to ex-
4 pand the role of the Federal Mediation and Conciliation
5 Service, acting through the Boards of Inquiry provided for
6 in limited terms under section 8(g) of the National Labor
7 Relations Act (29 U.S.C. 158(g)) and section 213 of the
8 Labor Management Relations Act of 1947 (29 U.S.C.
9 183), to avoid labor disputes by providing for public fact
10 finding in contract negotiations.

11 **SEC. 1532. APPLICATION LIMITED TO TRANSITION PERIOD.**

12 The provisions of this part are intended to avoid cost-
13 ly and disruptive labor disputes during the period of tran-
14 sition to a restructured health care delivery system, and
15 shall be repealed effective upon the end of calendar year
16 2000.

17 **SEC. 1533. REQUEST FOR APPOINTMENT OF BOARD OF IN-**
18 **QUIRY.**

19 (a) IN GENERAL.—A health care entity (as defined
20 in section 3082(a)) or a labor organization that has been
21 lawfully certified or recognized as the representative of the
22 employees of a health care entity for the purpose of engag-
23 ing in collective bargaining concerning wages, hours and
24 other terms and conditions of employment, may request
25 that the Director of the Federal Mediation and Concilia-

1 tion Service (hereafter referred to in this part as the “Di-
 2 rector”) appoint an impartial Health Care Board of In-
 3 quiry to investigate the issues involved in a collective bar-
 4 gaining dispute between the entity and the labor organiza-
 5 tion.

6 (b) TIME FOR REQUEST.—Such request may be made
 7 no earlier than 60 days after notice of the existence of
 8 a contract dispute has been provided to—

9 (1) the Federal Mediation and Conciliation
 10 Service in accordance with clause (A) or (B) of the
 11 last sentence of section 8(d) of the Labor Manage-
 12 ment Relations Act (29 U.S.C. 158(d)); or

13 (2) where the health care entity is otherwise ex-
 14 empt from coverage under such Act, any comparable
 15 State or territorial agency established to mediate
 16 and conciliate disputes to which notice is required to
 17 be given under applicable State law.

18 **SEC. 1534. APPOINTMENT OF BOARD OF INQUIRY.**

19 (a) IN GENERAL.—Except as provided in subsection
 20 (b), the Director shall appoint a Health Care Board of
 21 Inquiry not later than 10 days after receipt of a request
 22 under section 1532. Each such Board shall be composed
 23 of such number of individuals as the Director may deem
 24 desirable. No member appointed under this section shall
 25 have any interest or involvement in the health care institu-

1 tions or the employee organizations involved in the dis-
2 pute.

3 (b) LIMITATION.—With respect to the appointment
4 of a Health Care Board of Inquiry under paragraph (1),
5 if the Director determines that—

6 (1) the health care entity is—

7 (A) otherwise exempt from coverage under
8 the Labor Management Relations Act, as
9 amended (29 U.S.C. 141 et seq.); and

10 (B) subject to State laws containing proce-
11 dures for the resolution of impasses in collective
12 bargaining that are comparable to those that
13 would be followed by a Board of Inquiry under
14 this section; or

15 (2) the parties involved have agreed to proce-
16 dures for the resolution of the impasse in collective
17 bargaining that are comparable to those that would
18 be followed by a Board of Inquiry;

19 the Director may refuse the request for the appointment
20 of such a Board.

21 **SEC. 1535. PUBLIC FACTFINDING.**

22 A Health Care Board of Inquiry appointed under this
23 part shall investigate the issues involved in the dispute and
24 make a written report thereon to the parties and to the
25 Director within 30 days after the establishment of such

1 a Board. The written report shall contain the findings of
2 fact together with the Board's recommendations for set-
3 tling the dispute, with the objective of achieving a prompt,
4 peaceful and just settlement of the dispute. The Board
5 shall arrange for publication of such report within the
6 community served by the health care entity involved.

7 **SEC. 1535A. COMPENSATION OF MEMBERS OF BOARDS OF**
8 **INQUIRY.**

9 (a) EMPLOYEES IF FEDERAL GOVERNMENT.—Mem-
10 bers of any board established under this part who are oth-
11 erwise employed by the Federal Government shall serve
12 without compensation but shall be reimbursed for travel,
13 subsistence, and other necessary expenses incurred by
14 such members in carrying out its duties under this section.

15 (b) OTHER MEMBERS.—Members of any board estab-
16 lished under this section who are not subject to subsection
17 (a) shall receive compensation at a rate prescribed by the
18 Director but not to exceed the daily rate prescribed for
19 GS-12 of the General Schedule under section 5332 of title
20 5, United States Code, including travel for each day they
21 are engaged in the performance of their duties under this
22 section and shall be entitled to reimbursement for travel,
23 subsistence, and other necessary expenses incurred by
24 them in carrying out their duties under this part.

1 **SEC. 1535B. MAINTENANCE OF STATUS QUO.**

2 After the establishment of a board under section
3 1533, and for 15 days after any such board has issued
4 its report, no change in the status quo in effect prior to
5 the expiration of the contract in the case of negotiations
6 for a contract renewal, or in effect prior to the time the
7 parties began their bargaining in the case of an initial be-
8 ginning negotiation, except by agreement, shall be made
9 by the parties to the controversy.

10 **Subtitle G—Miscellaneous**
11 **Employer Requirements**

12 **SEC. 1601. AUDITING OF RECORDS.**

13 Each community-rated employer shall maintain such
14 records, and provide the State for the area in which the
15 employer maintains the principal place of employment (as
16 specified by the Secretary of Labor) with access to such
17 records, as may be necessary to verify and audit the infor-
18 mation reported under this Act.

19 **SEC. 1602. PROHIBITION OF CERTAIN EMPLOYER DISCRIMI-**
20 **NATION.**

21 No employer may discriminate with respect to an em-
22 ployee on the basis of the family status of the employee
23 or on the basis of the class of family enrollment selected
24 with respect to the employee.

1 **SEC. 1603. EVASION OF OBLIGATIONS.**

2 It shall be unlawful for any employer or other person
3 to discharge, fine, suspend, expel, discipline, discriminate
4 or otherwise take adverse action against any employee if
5 a purpose of such action is to interfere with the employee's
6 attainment of status as a qualifying employee, as a full
7 time employee, or as a part-time employee, or if a purpose
8 of such action is to evade or avoid any obligation under
9 this Act.

10 **SEC. 1604. PROHIBITION ON SELF-FUNDING OF COST SHAR-**
11 **ING BENEFITS.**

12 (a) PROHIBITION.—A community-rated employer
13 (and an experience-rated employer with respect to employ-
14 ees who are community rated eligible individuals) may pro-
15 vide benefits to employees that consist of the benefits in-
16 cluded in a cost sharing policy only through a contribution
17 toward the purchase of a cost sharing policy which is fund-
18 ed primarily through insurance.

19 (b) INDIVIDUAL AND EMPLOYER RESPONSIBIL-
20 ITIES.—In the case of an individual who resides in a sin-
21 gle-payer State and an employer with respect to employees
22 who reside in such a State, the responsibilities of such in-
23 dividual and employer under such system shall supersede
24 the obligations of the individual and employer under this
25 subtitle.

1 **SEC. 1605. ENFORCEMENT.**

2 In the case of a person that violates a requirement
 3 of this subtitle, the Secretary of Labor may impose a civil
 4 money penalty, in an amount not to exceed \$10,000, for
 5 each violation with respect to each individual.

6 **Subtitle H—General Definitions;**
 7 **Miscellaneous Provisions**

8 **PART 1—GENERAL DEFINITIONS**

9 **SEC. 1700. DEFINITIONS AND SPECIAL RULES RELATING TO**
 10 **HEALTH PLANS.**

11 For purposes of this Act—

12 (1) HEALTH PLAN.—

13 (A) IN GENERAL.—The term “health plan”
 14 means an insured health plan or a self-insured
 15 health plan which provides, or pays the cost of,
 16 health benefits. Such term does not include the
 17 following, or any combination thereof:

18 (i) Coverage only for accidental death
 19 or dismemberment.

20 (ii) Coverage providing wages or pay-
 21 ments in lieu of wages for any period dur-
 22 ing which the employee is absent from
 23 work on account of sickness or injury.

24 (iii) A medicare supplemental policy
 25 (as defined in section 1882(g)(1) of the
 26 Social Security Act).

1 (iv) Coverage issued as a supplement
2 to liability insurance.

3 (v) General liability insurance.

4 (vi) Worker's compensation or similar
5 insurance.

6 (vii) Automobile or automobile medi-
7 cal-payment insurance.

8 (viii) A long-term care policy, includ-
9 ing a nursing home fixed indemnity policy
10 (unless the Secretary determines that such
11 a policy provides sufficiently comprehensive
12 coverage of a benefit so that it should be
13 treated as a health plan).

14 (ix) A specified disease or illness in-
15 surance policy.

16 (x) A hospital or fixed indemnity in-
17 come-protection policy.

18 (xi) A disability income policy.

19 (xii) Insurance with respect to acci-
20 dents.

21 (xiii) An equivalent health care pro-
22 gram.

23 (xiv) Such other plan or arrangement
24 as the Secretary determines is not a health
25 plan.

1 (B) INSURED HEALTH PLAN.—

2 (i) IN GENERAL.—The term “insured
3 health plan” means any health plan which
4 is a hospital or medical service policy or
5 certificate, hospital or medical service plan
6 contract, or health maintenance organiza-
7 tion or preferred provider organization
8 group contract offered by an insurer.

9 (ii) INSURER.—The term “insurer”
10 means—

11 (I) a licensed insurance company,

12 (II) a prepaid hospital or medical
13 service plan,

14 (III) a preferred provider organi-
15 zation,

16 (IV) a health maintenance orga-
17 nization, or

18 (V) any similar entity (other than
19 an entity described in subparagraph
20 (C)),

21 which is engaged in the business of provid-
22 ing a plan of health insurance or health
23 benefits.

1 (C) SELF-INSURED HEALTH PLAN.—The
2 term “self-insured health plan” means a health
3 plan—

4 (i) which is established and main-
5 tained by a large employer, and

6 (ii) under which the large employer
7 retains a substantial risk for the providing
8 of health benefits under the plan.

9 (D) NETWORK PLAN.—The term “network
10 plan” means a health plan with which providers
11 have entered into an agreement that obligates
12 such providers to provide items and services to
13 individuals enrolled in the plan, or an agree-
14 ment to provide items and services on a fee-for-
15 service basis.

16 (E) POINT-OF-SERVICE PLAN.—The term
17 “point-of-service plan” means a network plan
18 that provides reimbursement for items and serv-
19 ices provided out-of-network at increased cost-
20 sharing levels.

21 (F) FEE-FOR-SERVICE PLAN.—The term
22 “fee-for-service plan” means a health plan
23 that—

24 (i) provides coverage for all items and
25 services included in the comprehensive ben-

1 efit package that are furnished by any law-
2 ful health care provider of the enrollee's
3 choice, subject to reasonable restrictions,
4 as determined by the Secretary, and

5 (ii) makes payment to such a provider
6 without regard to whether or not there is
7 a contractual arrangement between the
8 plan and the provider.

9 (2) CERTIFIED HEALTH PLAN.—The term “cer-
10 tified health plan” means a health plan which is cer-
11 tified by the appropriate certifying authority as
12 meeting the applicable requirements of this Act, in-
13 cluding the offering of the comprehensive benefits
14 described in subtitle B. A health plan shall not fail
15 to be treated as a certified health plan if such plan
16 offers a medicare-eligible benefits package to medi-
17 care beneficiaries under—

18 (A) a contract entered into with the Sec-
19 retary under section 1876 of the Social Security
20 Act, or

21 (B) a plan of an organization providing
22 benefits pursuant to an agreement under sec-
23 tion 1833(a)(1)(A) of such Act.

24 (3) TERMS AND RULES RELATING TO COMMU-
25 NITY AND EXPERIENCE RATING.—

1 (A) COMMUNITY-RATED HEALTH PLAN.—

2 The term “community-rated health plan”
3 means a health plan which meets the require-
4 ments of section 1013.

5 (B) COMMUNITY-RATED INDIVIDUAL.—The
6 term “community-rated individual” means an
7 individual—

8 (i) who is not an experience-rated in-
9 dividual, or

10 (ii) who is an experience-rated individ-
11 ual (determined without regard to this sub-
12 paragraph) who is not a full-time employee
13 of a large employer and who does not en-
14 roll in a certified health plan offered by the
15 employer.

16 (C) SMALL EMPLOYER.—The term “small
17 employer” means, with respect to any calendar
18 year, any employer if, on each of 20 days dur-
19 ing the preceding calendar year (each day being
20 in a different week), such employer (or any
21 predecessor) employed less than 100 full-time
22 employees for the day.

23 (D) EXPERIENCE-RATED HEALTH PLAN.—
24 The term “experience-rated health plan” means

1 an insured or self-insured health plan covering
2 only experience-rated individuals.

3 (E) EXPERIENCE-RATED INDIVIDUAL.—

4 The term “experience-rated individual” means
5 an individual who is—

6 (i) an employee (or the dependent of
7 an employee) of a large employer,

8 (ii) a member (or the dependent of a
9 member) of a qualified association plan (as
10 defined in section 1323), or

11 (iii) an individual enrolled in a plan to
12 which section 1325 applies.

13 (F) LARGE EMPLOYER.—

14 (i) IN GENERAL.—The term “large
15 employer” means, with respect to any cal-
16 endar year, any employer if, on each of 20
17 days during the preceding calendar year
18 (each day being in a different week), such
19 employer (or any predecessor) employed
20 100 or more full-time employees for the
21 day.

22 (ii) ELECTION NOT TO AGGREGATE.—

23 Any employer may elect not to aggregate
24 its employees across community rating
25 areas. Upon such election, the employer

1 shall be treated as a small employer in any
2 community rating area in which it employs
3 less than 100 full-time employees and as a
4 large employer in any community rating
5 area in which it employs 100 or more full-
6 time employees. Such election shall remain
7 in effect for a period of not less than 5
8 years. An employer may revoke such elec-
9 tion after a 5-year period by notifying the
10 Secretary of Labor under rules prescribed
11 by the Secretary.

12 (G) SPECIAL RULE FOR SPOUSES AND DE-
13 PENDENTS.—If any individual is offered cov-
14 erage under a health plan as the spouse or a
15 dependent of a primary enrollee of such plan,
16 such individual shall have the status of such en-
17 rollee unless such individual is eligible to elect
18 other coverage and so elects.

19 **SEC. 1701. DEFINITIONS RELATING TO EMPLOYMENT AND**
20 **INCOME.**

21 (a) IN GENERAL.—Except as otherwise specifically
22 provided, in this Act the following definitions and rules
23 apply:

1 (1) EMPLOYER, EMPLOYEE, EMPLOYMENT, AND
2 WAGES DEFINED.—Except as provided in this sec-
3 tion—

4 (A) the terms “wages” and “employment”
5 have the meanings given such terms under sec-
6 tion 3121 of the Internal Revenue Code of
7 1986,

8 (B) the term “employee” has the meaning
9 given such term under section 3121 of such
10 Code, subject to the provisions of chapter 25 of
11 such Code, and

12 (C) the term “employer” has the same
13 meaning as the term “employer” as used in
14 such section 3121.

15 (2) EXCEPTIONS.—For purposes of paragraph
16 (1)—

17 (A) EMPLOYMENT.—

18 (i) EMPLOYMENT INCLUDED.—Para-
19 graphs (1), (2), (5), (7) (other than
20 clauses (i) through (iv) of subparagraph
21 (C) and clauses (i) through (v) of subpara-
22 graph (F)), (8), (9), (10), (11), (13), (15),
23 (18), and (19) of section 3121(b) of the
24 Internal Revenue Code of 1986 shall not
25 apply.

1 (ii) EXCLUSION OF INMATES AS EM-
2 PLOYEES.—Employment shall not include
3 services performed in a penal institution by
4 an inmate thereof or in a hospital or other
5 health care institution by a patient thereof.

6 (B) WAGES.—

7 (i) IN GENERAL.—Paragraph (1) of
8 section 3121(a) of the Internal Revenue
9 Code of 1986 shall not apply.

10 (ii) TIPS NOT INCLUDED.—The term
11 “wages” does not include cash tips.

12 (C) EXCLUSION OF CERTAIN FOREIGN EM-
13 PLOYMENT.—The term “employee” does not in-
14 clude an individual with respect to service, if
15 the individual is not a citizen or resident of the
16 United States and the service is performed out-
17 side the United States.

18 (3) AGGREGATION RULES FOR EMPLOYERS.—

19 For purposes of this Act—

20 (A) all employers treated as a single em-
21 ployer under subsection (a) or (b) of section 52
22 of the Internal Revenue Code of 1986 shall be
23 treated as a single employer, and

24 (B) under regulations of the Secretary of
25 Labor, all employees of organizations which are

1 under common control with one or more organi-
2 zations which are exempt from income tax
3 under subtitle A of the Internal Revenue Code
4 of 1986 shall be treated as employed by a single
5 employer.

6 The regulations prescribed under subparagraph (B)
7 shall be based on principles similar to the principles
8 which apply to taxable organizations under subpara-
9 graph (A).

10 (4) EMPLOYER PREMIUM.—The term “employer
11 premium” refers to the premium established and im-
12 posed under part 2 of subtitle B of title V.

13 (b) QUALIFYING EMPLOYEE; FULL-TIME EMPLOY-
14 MENT.—

15 (1) QUALIFYING EMPLOYEE.—

16 (A) IN GENERAL.—In this Act, the term
17 “qualifying employee” means, with respect to
18 an employer for a month, an employee (other
19 than a covered child, as defined in subpara-
20 graph (C)) who is employed by the employer for
21 at least 40 hours (as determined under para-
22 graph (3)) in the month, subject to the limita-
23 tion set forth in subparagraph (D).

24 (B) NO SPECIAL TREATMENT OF MEDI-
25 CARE BENEFICIARIES, SSI RECIPIENTS, AFDC

1 RECIPIENTS, AND OTHERS.—Subparagraph (A)
 2 shall apply regardless of whether or not the em-
 3 ployee is a medicare-eligible individual, an SSI
 4 recipient, an AFDC recipient, an eligible indi-
 5 vidual or is authorized to be so employed.

6 (C) COVERED CHILD DEFINED.—In sub-
 7 paragraph (A), the term “covered child” means
 8 an eligible individual who is a child and is en-
 9 rolled under a health plan as a family member
 10 described in section 1011(b).

11 (D) QUALIFYING EMPLOYEES.—As used in
 12 this Act—

13 (i) the term qualifying employee shall
 14 not include, with respect to an employer
 15 for a month, an employee of a nonelecting
 16 small employer (as defined in section
 17 6120); and

18 (ii) the term “qualifying employee”
 19 shall include, with respect to an employer
 20 for a month, a part-time employee begin-
 21 ning with the second month of such em-
 22 ployee’s employment.

23 (2) FULL-TIME EQUIVALENT EMPLOYEES;
 24 PART-TIME EMPLOYEES.—

1 (A) IN GENERAL.—For purposes of this
2 Act, a qualifying employee who is employed by
3 an employer—

4 (i) for at least 120 hours in a month,
5 is counted as 1 full-time equivalent em-
6 ployee for the month and shall be deemed
7 to be employed on a full-time basis, or

8 (ii) for at least 40 hours, but less
9 than 120 hours, in a month, is counted as
10 a fraction of a full-time equivalent em-
11 ployee in the month equal to the full-time
12 employment ratio for the employee and
13 shall be deemed to be employed on a part-
14 time basis.

15 (B) FULL-TIME EMPLOYEE.—For purposes
16 of this Act, the term “full-time employee”
17 means, with respect to an employer, an em-
18 ployee who is employed on a full-time basis (as
19 specified in subparagraph (A)) by the employer.

20 (C) PART-TIME EMPLOYEE.—For purposes
21 of this Act, the term “part-time employee”
22 means, with respect to an employer, an em-
23 ployee who is employed on a part-time basis (as
24 specified in subparagraph (A)) by the employer.

1 (D) CONSIDERATION OF INDUSTRY PRAC-
2 TICE.—As provided under rules established by
3 the Secretary, an employee who is not described
4 in subparagraph (B) or (C) shall be considered
5 to be employed on a full-time or part-time basis
6 by an employer (and to be a full-time or part-
7 time employee of an employer) for a month (or
8 for all months in a 12-month period) if the em-
9 ployee is employed by that employer on a con-
10 tinuing basis that, taking into account the
11 structure or nature of employment in the indus-
12 try, represents full or part-time employment in
13 that industry.

14 (E) INSTITUTIONS OF HIGHER EDU-
15 CATION.—Notwithstanding any other provision
16 in this section—

17 (i)(I) employees of an Institution of
18 higher education (as defined in section
19 1201(a) of the Higher Education Act of
20 1965), or of an elementary or secondary
21 school (as defined in section 1471 of the
22 Elementary and Secondary Education Act
23 of 1965), who are exempt under section 13
24 of the Fair Labor Standards Act, shall be
25 deemed to be full-time employees if they

1 work the hours that constitute full-time
2 employment as defined at such institution;

3 (II) part-time employment shall be
4 considered proportional to such hours for
5 full-time employees; and

6 (III) part-time employees who work at
7 least one-third of the hours that constitute
8 full-time employment as defined at such in-
9 stitution shall be eligible for proportional
10 employer premium contributions; and

11 (ii) regular employees of institutions
12 of higher education or elementary and sec-
13 ondary schools who are not paid during the
14 summer months or other periods of the
15 year, but are assured employment at the
16 end of such periods, shall be eligible for
17 year-round employer premium contribu-
18 tions if such individuals are not eligible to
19 collect unemployment compensation for the
20 periods for which they would receive health
21 care premium contributions from the em-
22 ployer covered by this subsection.

23 (3) TREATMENT OF SALARIED EMPLOYEES AND
24 EMPLOYEES PAID ON CONTINGENT OR BONUS AR-
25 RANGEMENTS.—In the case of an employee who re-

1 ceives compensation on a salaried basis or on the
 2 basis of a commission (or other contingent or bonus
 3 basis), rather than an hourly wage, the Secretary
 4 shall establish rules for the conversion of the com-
 5 pensation to hours of employment.

6 (c) DEFINITIONS RELATING TO SELF-EMPLOY-
 7 MENT.—In this Act:

8 (1) NET EARNINGS FROM SELF-EMPLOY-
 9 MENT.—The term “net earnings from self-employ-
 10 ment” has the meaning given such term under sec-
 11 tion 1402(a) of the Internal Revenue Code of 1986.

12 (2) SELF-EMPLOYED INDIVIDUAL.—The term
 13 “self-employed individual” means, for a year, an in-
 14 dividual who has net earnings from self-employment
 15 for the year.

16 (d) CONSUMER PRICE INDEX; CPI.—The terms
 17 “consumer price index” and “CPI” mean the Consumer
 18 Price Index for all urban consumers (U.S. city average),
 19 as published by the Bureau of Labor Statistics.

20 **SEC. 1702. OTHER GENERAL DEFINITIONS.**

21 Except as otherwise specifically provided, in this Act
 22 the following definitions apply:

23 (1) APPLICABLE HEALTH PLAN.—The term
 24 “applicable health plan” means, with respect to an

1 eligible individual, the health plan specified pursuant
2 to section 1004 and part 2 of subtitle A.

3 (2) CITIZEN OF ANOTHER COUNTRY LEGALLY
4 RESIDING IN THE UNITED STATES.—The term “citi-
5 zen of another country legally residing in the United
6 States” means an alien lawfully admitted for perma-
7 nent residence, or otherwise permanently residing,
8 in the United States under color of law as included
9 in regulations in effect under title XIX of the Social
10 Security Act as of December 1, 1994.

11 (3) COVERED WAGES DEFINED.—In this sec-
12 tion, the term “covered wages” means wages paid an
13 employee of an employer during a month in which
14 the employee was a qualifying employee of the em-
15 ployer.

16 (4) EXEMPT INDIVIDUAL.—The term “exempt
17 individual” means an individual that has been grant-
18 ed an exemption from paying Social Security Taxes
19 under section 1402(g) of the Internal Revenue Code
20 of 1986, or an individual who would be eligible for
21 an exemption under such section if the individual
22 were self-employed.

23 (5) HEALTH PLAN SPONSOR.—The term
24 “health plan sponsor” means—

1 (A) with respect to a community-rated
2 plan, the carrier providing the plan,

3 (B) with respect to an insured experience-
4 rated plan, the carrier providing the plan, and

5 (C) with respect to a self-funded experi-
6 ence-rated plan, the employer providing the
7 plan.

8 (6) LONG-TERM NONIMMIGRANT.—The term
9 “long-term nonimmigrant” means a nonimmigrant
10 described in subparagraph (E), (H), (I), (J), (K),
11 (L), (M), (N), (O), (Q), or (R) of section 101(a)(15)
12 of the Immigration and Nationality Act or an alien
13 within such other classification of nonimmigrant as
14 the Secretary may establish by regulation.

15 (7) POVERTY LEVEL.—The term “applicable
16 poverty level” means, for a family for a year, the of-
17 ficial poverty line (as defined by the Office of Man-
18 agement and Budget, and revised annually in ac-
19 cordance with section 673(2) of the Omnibus Budget
20 Reconciliation Act of 1981) applicable to a family of
21 the size involved for 1994.

22 (8) SECRETARY.—The term “Secretary” unless
23 expressly provided otherwise, means the Secretary of
24 Health and Human Services.

1 **PART 2—MISCELLANEOUS PROVISIONS**

2 **SEC. 1711. REGULATORY AUTHORITY.**

3 The Secretary of Health and Human Services and the
4 Secretary of Labor are each authorized to issue regula-
5 tions as are necessary to implement this Act. In order to
6 permit the timely implementation of the provisions of this
7 Act, such regulations may be issued on an interim basis.
8 Such regulations shall become final on the date of publica-
9 tion, subject to change based on subsequent public com-
10 ment.

11 **SEC. 1712. NEUTRALITY CONCERNING UNION ORGANIZING.**

12 Amounts appropriated to carry out this Act may not
13 be utilized to assist, promote or deter union organizing.

14 **SEC. 1713. SOCIAL SECURITY ACT REFERENCES.**

15 Except as may otherwise be provided, any reference
16 in this title, or in title V, to a provision of the Social Secu-
17 rity Act shall be to that provision of the Social Security
18 Act as in effect on the date of the enactment of this Act.

19 **SEC. 1714. COVERAGE OF BENEFITS UNDER AFFORDABLE**
20 **HEALTH CARE FOR ALL AMERICANS ACT.**

21 (a) DAVIS-BACON ACT.—Subsection (b)(2) of the
22 first section of the Davis Bacon Act (40 U.S.C.
23 276a(b)(2)) is amended in the matter following subpara-
24 graph (B) by inserting after “local law” the following:
25 “(other than benefits provided pursuant to the Affordable
26 Health Care For all Americans Act)”.

1 (b) SERVICE CONTRACT ACT OF 1965.—The second
 2 sentence of section 2(a)(2) of the Service Contract Act of
 3 1965 (41 U.S.C. 351(a)(2)) is amended by inserting after
 4 “local law” the following: “(other than benefits provided
 5 pursuant to the Affordable Health Care for All Americans
 6 Act)”.

7 **SEC. 1715. SENSE OF THE COMMITTEE CONCERNING FUND-**
 8 **ING SOURCES.**

9 It is the sense of the Committee on Labor and
 10 Human Resources of the Senate that when the Affordable
 11 Health Care for All Americans Act is enacted it should
 12 include the following sources of financing not within the
 13 jurisdiction of the Committee:

14 (1) The net savings and revenues included in
 15 S.1757, the Health Security Act (as introduced in
 16 the 103d Congress) which are outside the jurisdic-
 17 tion of the Committee.

18 (2) An increase in the cigarette tax of 75 cents
 19 per pack in excess of the amount specified in
 20 S.1757, the Health Security Act.

21 (3) A phased-in premium assessment, not to ex-
 22 ceed 1 percent, equal to the additional amount pro-
 23 vided for biomedical research under title III of this
 24 Act.

1 (4) Such other savings or revenues as are nec-
 2 essary, if any, to provide budget neutrality based on
 3 estimates of the Congressional Budget Office.

4 (5) A one percent payroll assessment on exempt
 5 employers with five or fewer workers and a two per-
 6 cent payroll assessment on exempt employers with
 7 six to 10 workers payable to the State to defray a
 8 portion of the additional subsidy costs for employees
 9 of such employers.

10 **TITLE II—NEW BENEFITS**
 11 **Subtitle A—Home and Community-**
 12 **Based Services**

13 **PART 1—HOME AND COMMUNITY-BASED**
 14 **SERVICES FOR INDIVIDUALS WITH DISABILITIES**

15 **SEC. 2101. STATE PLANS.**

16 (a) PLAN REQUIREMENTS.—In order to be approved
 17 under subsection (b), a State plan for home and commu-
 18 nity-based services for individuals with disabilities must
 19 meet the following requirements:

20 (1) STATE MAINTENANCE OF EFFORT.—

21 (A) IN GENERAL.—A State plan under this
 22 subtitle shall provide that the State will, during
 23 any fiscal year that the State is furnishing serv-
 24 ices under this subtitle, make expenditures of
 25 State funds in an amount equal to the State

1 maintenance of effort amount for the year de-
 2 termined under subparagraph (B) for furnish-
 3 ing the services described in subparagraph (C)
 4 under the State plan under this subtitle and the
 5 State plan under title XIX of the Social Secu-
 6 rity Act.

7 (B) STATE MAINTENANCE OF EFFORT
 8 AMOUNT.—

9 (i) IN GENERAL.—The maintenance of
 10 effort amount for a State for a fiscal year
 11 is an amount equal to—

12 (I) for fiscal year 1999, the base
 13 amount for the State (as determined
 14 under clause (ii)) updated through the
 15 midpoint of fiscal year 1998 by the
 16 estimated percentage change in the
 17 consumer price index during the pe-
 18 riod beginning on October 1, 1994
 19 and ending at that midpoint; and

20 (II) for succeeding fiscal years,
 21 an amount equal to the amount deter-
 22 mined under this clause for the pre-
 23 vious fiscal year updated through the
 24 midpoint of the year by the estimated
 25 percentage change in the consumer

1 price index during the 12-month pe-
2 riod ending at that midpoint, with ap-
3 propriate adjustments to reflect pre-
4 vious underestimations or overesti-
5 mations under this clause in the pro-
6 jected percentage change in the
7 consumer price index.

8 (ii) STATE BASE AMOUNT.—The base
9 amount for a State is an amount equal to
10 the total expenditures from State funds
11 made under the State plan under title XIX
12 of the Social Security Act during fiscal
13 year 1994 with respect to medical assist-
14 ance consisting of the services described in
15 subparagraph (C).

16 (C) MEDICAID SERVICES DESCRIBED.—
17 The services described in this subparagraph are
18 the following:

19 (i) Personal care services (as de-
20 scribed in section 1905(a)(24) of the Social
21 Security Act).

22 (ii) Home or community-based serv-
23 ices furnished under a waiver granted
24 under subsection (c), (d), or (e) of section
25 1915 of such Act.

1 (iii) Home and community care fur-
2 nished to functionally disabled elderly indi-
3 viduals under section 1929 of such Act.

4 (iv) Community supported living ar-
5 rangements services under section 1930 of
6 such Act.

7 (2) ELIGIBILITY.—

8 (A) IN GENERAL.—Except as provided in
9 subparagraph (B), within the amounts provided
10 by the State and under section 2107 for such
11 plan, the plan shall provide that services under
12 the plan will be available to individuals with dis-
13 abilities (as defined in section 2102(a)) in the
14 State.

15 (B) INITIAL SCREENING.—The plan shall
16 provide a process for the initial screening of an
17 individual who appears to have some reasonable
18 likelihood of being an individual with disabili-
19 ties. Any such process shall require the provi-
20 sion of assistance to individuals who wish to
21 apply but whose disability limits their ability to
22 apply. The initial screening and the determina-
23 tion of disability (as defined under section
24 2102(b)(1)) shall be conducted by a public
25 agency.

1 (C) RESTRICTIONS.—The plan may not
2 limit the eligibility of individuals with disabil-
3 ities based on—

4 (i) income,

5 (ii) age,

6 (iii) residential setting (other than an
7 institutional setting), or

8 (iv) other grounds specified by the
9 Secretary.

10 (D) CONTINUATION OF SERVICES.—The
11 plan must provide assurances that, in the case
12 of an individual receiving medical assistance for
13 home and community-based services under the
14 State medicaid plan under title XIX of the So-
15 cial Security Act as of the date a State's plan
16 is approved under this subtitle, the State will
17 continue to make available (either under this
18 plan, under the State medicaid plan, or other-
19 wise) to such individual an appropriate level of
20 assistance for home and community-based serv-
21 ices, taking into account the level of assistance
22 provided as of such date and the individual's
23 need for home and community-based services.

24 (3) SERVICES.—

1 (A) NEEDS ASSESSMENT.—Not later than
2 the end of the second year of implementation,
3 the plan or its amendments shall include the re-
4 sults of a statewide assessment of the needs of
5 individuals with disabilities in a format required
6 by the Secretary. The needs assessment shall
7 include demographic data concerning the num-
8 ber of individuals within each category of dis-
9 ability described in this subtitle, and the serv-
10 ices available to meet the needs of such individ-
11 uals.

12 (B) SPECIFICATION.—Consistent with sec-
13 tion 2103, the plan shall specify—

14 (i) the services made available under
15 the plan,

16 (ii) the extent and manner in which
17 such services are allocated and made avail-
18 able to individuals with disabilities, and

19 (iii) the manner in which services
20 under the plan are coordinated with each
21 other and with health and long-term care
22 services available outside the plan for indi-
23 viduals with disabilities.

24 (C) TAKING INTO ACCOUNT INFORMAL
25 CARE.—A State plan may take into account, in

1 determining the amount and array of services
2 made available to covered individuals with dis-
3 abilities, the availability of informal care.

4 (D) ALLOCATION.—The State plan—

5 (i) shall specify how services under
6 the plan will be allocated among covered
7 individuals with disabilities,

8 (ii) shall attempt to meet the needs of
9 individuals with a variety of disabilities
10 within the limits of available funding,

11 (iii) shall include services that assist
12 all categories of individuals with disabil-
13 ities, regardless of their age or the nature
14 of their disabling conditions,

15 (iv) shall demonstrate that services
16 are allocated equitably, in accordance with
17 the needs assessment required under sub-
18 paragraph (A), and

19 (v) shall ensure that—

20 (I) the proportion of the popu-
21 lation of low-income individuals with
22 disabilities in the State that rep-
23 resents individuals with disabilities
24 who are provided home and commu-
25 nity-based services either under the

1 plan, under the State medicaid plan,
 2 or under both, is not less than,

3 (II) the proportion of the popu-
 4 lation of the State that represents in-
 5 dividuals who are low-income individ-
 6 uals.

7 (E) LIMITATION ON LICENSURE OR CER-
 8 TIFICATION.—The State may not subject
 9 consumer-directed providers of personal assist-
 10 ance services to licensure, certification, or other
 11 requirements which the Secretary finds not to
 12 be necessary for the health and safety of indi-
 13 viduals with disabilities.

14 (F) CONSUMER CHOICE.—To the extent
 15 feasible, the State shall follow the choice of an
 16 individual with disabilities (or that individual's
 17 designated representative who may be a family
 18 member) regarding which covered services to re-
 19 ceive and the providers who will provide such
 20 services.

21 (4) COST SHARING.—The plan shall impose cost
 22 sharing with respect to covered services in accord-
 23 ance with section 2104.

24 (5) TYPES OF PROVIDERS AND REQUIREMENTS
 25 FOR PARTICIPATION.—The plan shall specify—

1 (A) the types of service providers eligible
2 to participate in the program under the plan,
3 which shall include consumer-directed providers
4 of personal assistance services, except that the
5 plan—

6 (i) may not limit benefits to services
7 provided by registered nurses or licensed
8 practical nurses; and

9 (ii) may not limit benefits to services
10 provided by agencies or providers certified
11 under title XVIII; and

12 (B) any requirements for participation ap-
13 plicable to each type of service provider.

14 (6) PROVIDER REIMBURSEMENT.—

15 (A) PAYMENT METHODS.—The plan shall
16 specify the payment methods to be used to re-
17 imburse providers for services furnished under
18 the plan. In the case of payment to consumer-
19 directed providers of personal assistance serv-
20 ices, including payment through the use of cash
21 or vouchers, the plan shall specify how the plan
22 will assure compliance with applicable employ-
23 ment tax and health care coverage provisions.

1 (B) PAYMENT RATES.—The plan shall
2 specify the methods and criteria to be used to
3 set payment rates.

4 (C) PLAN PAYMENT AS PAYMENT IN
5 FULL.—The plan shall restrict payment under
6 the plan for covered services to those providers
7 that agree to accept the payment under the
8 plan (at the rates established pursuant to sub-
9 paragraph (B)) and any cost sharing permitted
10 or provided for under section 2104 as payment
11 in full for services furnished under the plan.

12 (7) QUALITY ASSURANCE AND SAFEGUARDS.—
13 The State plan shall provide for quality assurance
14 and safeguards for applicants and beneficiaries in
15 accordance with section 2105.

16 (8) ADVISORY GROUP.—The State plan shall
17 assure the establishment and maintenance of an ad-
18 visory group under section 2106(b).

19 (9) ADMINISTRATION AND ACCESS.—

20 (A) STATE AGENCY.—The plan shall des-
21 ignate a State agency or agencies to administer
22 (or to supervise the administration of) the plan.

23 (B) COORDINATION.—The plan shall speci-
24 fy how it will—

1 (i) coordinate services provided under
2 the plan, including eligibility prescreening,
3 service coordination, and referrals for indi-
4 viduals with disabilities who are ineligible
5 for services under this subtitle with other
6 Federal or State programs that provide
7 services or assistance targeted to individ-
8 uals with disabilities; and

9 (ii) coordinate with health plans.

10 (C) ADMINISTRATIVE EXPENDITURES.—

11 Effective beginning with fiscal year 2004, the
12 plan shall contain assurances that not more
13 than 10 percent of expenditures under the plan
14 for all quarters in any fiscal year shall be for
15 administrative costs.

16 (10) REPORTS AND INFORMATION TO SEC-

17 RETARY; AUDITS.—The plan shall provide that the
18 State will furnish to the Secretary such data and in-
19 formation as the Secretary may require in a uniform
20 format as specified by the Secretary.

21 (11) USE OF STATE FUNDS FOR MATCHING.—

22 The plan shall provide assurances that Federal
23 funds will not be used to provide for the State share
24 of expenditures under this subtitle.

1 (12) HEALTH CARE WORKER REDEPLOY-
2 MENT.—The plan shall provide for the following:

3 (A) Before initiating the process of imple-
4 menting the State program under such plan,
5 negotiations will be commenced with labor
6 unions representing the employees of the af-
7 fected hospitals or other facilities.

8 (B) Negotiations under subparagraph (A)
9 will address the following:

10 (i) The impact of the implementation
11 of the program upon the workforce.

12 (ii) Methods to redeploy workers to
13 positions in the proposed system, in the
14 case of workers affected by the program.

15 (C) The plan will provide evidence that
16 there has been compliance with subparagraphs
17 (A) and (B), including a description of the re-
18 sults of the negotiations.

19 (13) TERMINOLOGY.—The plan shall adhere to
20 uniform definitions of terms, as specified by the Sec-
21 retary.

22 (b) APPROVAL OF PLANS.—The Secretary shall ap-
23 prove a plan submitted by a State if the Secretary deter-
24 mines that the plan—

1 (1) was developed by the State after a public
2 comment period of not less than 30 days, and

3 (2) meets the requirements of subsection (a).

4 The approval of such a plan shall take effect as of the
5 first day of the first fiscal year beginning after the date
6 of such approval (except that any approval made before
7 January 1, 1998, shall be effective as of January 1, 1998).
8 In order to budget funds allotted under this subtitle, the
9 Secretary shall establish a deadline for the submission of
10 such a plan before the beginning of a fiscal year as a con-
11 dition of its approval effective with that fiscal year. Any
12 significant changes to the State plan shall be submitted
13 to the Secretary in the form of plan amendments and shall
14 be subject to approval by the Secretary.

15 (c) MONITORING.—The Secretary shall annually
16 monitor the compliance of State plans with the require-
17 ments of this subtitle according to specified performance
18 standards. In accordance with section 2107(e), States that
19 fail to comply with such requirements may be subject to
20 a reduction in the Federal matching rates available to the
21 State under section 2107(a) or the withholding of Federal
22 funds for services or administration until such time as
23 compliance is achieved.

1 (d) REGULATIONS.—The Secretary shall issue such
2 regulations as may be appropriate to carry out this sub-
3 title on a timely basis.

4 **SEC. 2102. INDIVIDUALS WITH DISABILITIES DEFINED.**

5 (a) IN GENERAL.—For purposes of this subtitle, the
6 term ‘individual with disabilities’ means any individual
7 within one or more of the following categories of individ-
8 uals:

9 (1) INDIVIDUALS REQUIRING HELP WITH AC-
10 TIVITIES OF DAILY LIVING.—An individual of any
11 age who—

12 (A) requires hands-on or standby assist-
13 ance, supervision, or cueing (as defined in regu-
14 lations) to perform three or more activities of
15 daily living (as defined in subsection (d)), and

16 (B) is expected to require such assistance,
17 supervision, or cueing over a period of at least
18 90 days.

19 (2) INDIVIDUALS WITH SEVERE COGNITIVE OR
20 MENTAL IMPAIRMENT.—An individual of any age—

21 (A) whose score, on a standard mental sta-
22 tus protocol (or protocols) appropriate for
23 measuring the individual’s particular condition
24 specified by the Secretary, indicates either se-

1 vere cognitive impairment or severe mental im-
2 pairment, or both;

3 (B) who—

4 (i) requires hands-on or standby as-
5 sistance, supervision, or cueing with one or
6 more activities of daily living;

7 (ii) requires hands-on or standby as-
8 sistance, supervision, or cueing with at
9 least such instrumental activity (or activi-
10 ties) of daily living related to cognitive or
11 mental impairment as the Secretary speci-
12 fies; or

13 (iii) displays symptoms of one or more
14 serious behavioral problems (that is on a
15 list of such problems specified by the Sec-
16 retary) which create a need for supervision
17 to prevent harm to self or others; and

18 (C) who is expected to meet the require-
19 ments of subparagraphs (A) and (B) over a pe-
20 riod of at least 90 days.

21 Not later than 2 years after the date of enactment
22 of this subtitle, the Secretary shall make rec-
23 ommendations regarding the most appropriate dura-
24 tion of disability under this paragraph.

1 (3) INDIVIDUALS WITH SEVERE OR PROFOUND
2 MENTAL RETARDATION.—An individual of any age
3 who has severe or profound mental retardation (as
4 determined according to a protocol specified by the
5 Secretary).

6 (4) YOUNG CHILDREN WITH SEVERE DISABIL-
7 ITIES.—An individual under 6 years of age who—

8 (A) has a severe disability or chronic medi-
9 cal condition that limits functioning in a man-
10 ner that is comparable in severity to the stand-
11 ards established under paragraphs (1), (2), or
12 (3), and

13 (B) is expected to have such a disability or
14 condition and require such services over a pe-
15 riod of at least 90 days.

16 (b) DETERMINATION.—

17 (1) IN GENERAL.—In formulating eligibility cri-
18 teria under subsection (a), the Secretary shall estab-
19 lish criteria for assessing the functional level of dis-
20 ability among all categories of individuals with dis-
21 abilities that are comparable in severity, regardless
22 of the age or the nature of the disabling condition
23 of the individual. The determination of whether an
24 individual is an individual with disabilities shall be
25 made by a public or nonprofit agency that is speci-

1 fied under the State plan and that is not a provider
2 of home and community-based services under this
3 subtitle and by using a uniform protocol consisting
4 of an initial screening and a determination of dis-
5 ability specified by the Secretary. A State may not
6 impose cost sharing with respect to a determination
7 of disability. A State may collect additional informa-
8 tion, at the time of obtaining information to make
9 such determination, in order to provide for the as-
10 sessment and plan described in section 2103(b) or
11 for other purposes.

12 (2) PERIODIC REASSESSMENT.—The determina-
13 tion that an individual is an individual with disabil-
14 ities shall be considered to be effective under the
15 State plan for a period of not more than 6 months
16 (or for such longer period in such cases as a signifi-
17 cant change in an individual's condition that may af-
18 fect such determination is unlikely). A reassessment
19 shall be made if there is a significant change in an
20 individual's condition that may affect such deter-
21 mination.

22 (c) ACTIVITY OF DAILY LIVING DEFINED.—For pur-
23 poses of this subtitle, the term 'activity of daily living'
24 means any of the following: eating, toileting, dressing,
25 bathing, and transferring.

1 **SEC. 2103. HOME AND COMMUNITY-BASED SERVICES COV-**
2 **ERED UNDER STATE PLAN.**

3 (a) SPECIFICATION.—

4 (1) IN GENERAL.—Subject to the succeeding
5 provisions of this section, the State plan under this
6 subtitle shall specify—

7 (A) the home and community-based serv-
8 ices available under the plan to individuals with
9 disabilities (or to such categories of such indi-
10 viduals), and

11 (B) any limits with respect to such serv-
12 ices.

13 (2) FLEXIBILITY IN MEETING INDIVIDUAL
14 NEEDS.—Subject to subsection (f)(2), such services
15 may be delivered in an individual's home, a range of
16 community residential arrangements, or outside the
17 home.

18 (b) REQUIREMENT FOR NEEDS ASSESSMENT AND
19 PLAN OF CARE.—

20 (1) IN GENERAL.—The State plan shall provide
21 for home and community-based services to an indi-
22 vidual with disabilities only if the following require-
23 ments are met:

24 (A) COMPREHENSIVE ASSESSMENT.—A
25 comprehensive assessment of an individual's
26 need for home and community-based services

1 (regardless of whether all need services are
2 available under the plan) shall be made in ac-
3 cordance with a uniform, comprehensive assess-
4 ment tool that shall be used by a State under
5 this paragraph with the approval of the Sec-
6 retary. The Secretary shall provide guidance to
7 the States with regard to the appropriate quali-
8 fications for individuals who conduct com-
9 prehensive assessments.

10 (B) INDIVIDUALIZED PLAN OF CARE.—An
11 individualized plan of care based on the assess-
12 ment made under subparagraph (A) shall be de-
13 veloped. A plan of care under this subparagraph
14 shall—

15 (i) specify which services included
16 under the individual plan will be provided
17 under the State plan under this subtitle;

18 (ii) identify (to the extent possible)
19 how the individual will be provided any
20 services specified under the plan of care
21 and not provided under the State plan;

22 (iii) specify how the provision of serv-
23 ices to the individual under the plan will be
24 coordinated with the provision of other
25 health care services to the individual; and

1 (iv) be reviewed and updated every 6
2 months (or more frequently if there is a
3 change in the individual's condition).

4 The State shall make reasonable efforts to iden-
5 tify and arrange for services described in clause
6 (ii). Nothing in this subsection shall be con-
7 strued as requiring a State (under the State
8 plan or otherwise) to provide all the services
9 specified in such a plan.

10 (C) INVOLVEMENT OF INDIVIDUALS.—The
11 individualized plan of care under subparagraph
12 (B) for an individual with disabilities shall—

13 (i) be developed by qualified individ-
14 uals (specified under the State plan);

15 (ii) be developed and implemented in
16 close consultation with the individual (or
17 the individual's designated representative);
18 and

19 (iii) be approved by the individual (or
20 the individual's designated representative).

21 (c) REQUIREMENT FOR CARE MANAGEMENT.—

22 (1) IN GENERAL.—The State shall make avail-
23 able to each category of individuals with disabilities
24 care management services that at a minimum in-
25 clude—

1 (A) arrangements for the provision of such
2 services, and

3 (B) monitoring of the delivery of services.

4 (2) CARE MANAGEMENT SERVICES.—

5 (A) IN GENERAL.—Except as provided in
6 subparagraph (B), the care management serv-
7 ices described in paragraph (1) shall be pro-
8 vided by a public or private entity that is not
9 providing home and community-based services
10 under this subtitle.

11 (B) EXCEPTION.—A person who provides
12 home and community-based services under this
13 subtitle may provide care management services
14 if—

15 (i) the State determines that there is
16 an insufficient pool of entities willing to
17 provide such services in an area due to a
18 low population of individuals eligible for
19 home and community-based services under
20 this subtitle residing in such area; and

21 (ii) the State plan specifies procedures
22 that the State will implement in order to
23 avoid conflicts of interest.

24 (d) MANDATORY COVERAGE OF PERSONAL ASSIST-
25 ANCE SERVICES.—The State plan shall include, in the

1 array of services made available to each category of indi-
2 viduals with disabilities, both agency-administered and
3 consumer-directed personal assistance services (as defined
4 in subsection (h)).

5 (e) ADDITIONAL SERVICES.—Subject to subsection
6 (f), services available under a State plan under this sub-
7 title may include any (or all) of the following:

8 (1) Homemaker and chore assistance.

9 (2) Home modifications.

10 (3) Respite services.

11 (4) Assistive devices, as defined in the Tech-
12 nology Related Assistance for Individuals with Dis-
13 abilities Act.

14 (5) Adult day services.

15 (6) Habilitation and rehabilitation.

16 (7) Supported employment.

17 (8) Home health services.

18 (9) Transportation.

19 (10) Any other care or assistive services speci-
20 fied by the State and approved by the Secretary that
21 will help individuals with disabilities to remain in
22 their homes and communities.

23 (f) EXCLUSIONS AND LIMITATIONS.—A State plan
24 may not provide for coverage of—

25 (1) room and board,

1 (2) services furnished in a hospital, nursing fa-
2 cility, intermediate care facility for the mentally re-
3 tarded, or other institutional setting specified by the
4 Secretary, or

5 (3) items and services to the extent coverage is
6 provided for the individual under a health plan or
7 the medicare program.

8 (g) PAYMENT FOR SERVICES.—In order to pay for
9 covered services, a State plan may provide for the use of—

10 (1) vouchers,

11 (2) cash payments directly to individuals with
12 disabilities,

13 (3) capitation payments to health plans, and

14 (4) payment to providers.

15 (h) PERSONAL ASSISTANCE SERVICES.—

16 (1) IN GENERAL.—For purposes of this sub-
17 title, the term “personal assistance services” means
18 those services specified under the State plan as per-
19 sonal assistance services and shall include at least
20 hands-on and standby assistance, supervision, and
21 cueing with activities of daily living, whether agency-
22 administered or consumer-directed (as defined in
23 paragraph (2)).

24 (2) CONSUMER-DIRECTED.—For purposes of
25 this subtitle:

1 (A) IN GENERAL.—The term “consumer-
2 directed” means, with reference to personal as-
3 sistance services or the provider of such serv-
4 ices, services that are provided by an individual
5 who is selected and managed (and, at the op-
6 tion of the service recipient, trained) by the in-
7 dividual receiving the services.

8 (B) STATE RESPONSIBILITIES.—A State
9 plan shall ensure that where services are pro-
10 vided in a consumer-directed manner, the State
11 shall create or contract with an entity, other
12 than the consumer or the individual provider,
13 to—

14 (i) inform both recipients and provid-
15 ers of rights and responsibilities under all
16 applicable Federal labor and tax law; and

17 (ii) assume responsibility for providing
18 effective billing, payments for services, tax
19 withholding, unemployment insurance, and
20 workers’ compensation coverage, and act
21 as the employer of the home care provider.

22 (C) RIGHT OF CONSUMERS.—Notwith-
23 standing the State responsibilities described in
24 subparagraph (B), service recipients, and,
25 where appropriate, their designated representa-

1 tive, shall retain the right to independently se-
 2 lect, hire, terminate, and direct (including man-
 3 age, train, schedule, and verify services pro-
 4 vided) the work of a home care provider.

5 (3) AGENCY ADMINISTERED.—For purposes of
 6 this subtitle, the term ‘agency-administered’ means,
 7 with respect to such services, services that are not
 8 consumer-directed.

9 **SEC. 2104. COST SHARING.**

10 (a) NO COST SHARING FOR POOREST.—

11 (1) IN GENERAL.—The State plan may not im-
 12 pose any cost sharing for individuals with income (as
 13 determined under subsection (d)) less than 150 per-
 14 cent of the official poverty level (referred to in para-
 15 graph (2)) applicable to a family of the size involved.

16 (2) OFFICIAL POVERTY LEVEL.—The term ‘ap-
 17 plicable poverty level’ means, for a family for a year,
 18 the official poverty line (as defined by the Office of
 19 Management and Budget, and revised annually in
 20 accordance with section 673(2) of the Omnibus
 21 Budget Reconciliation Act of 1981) applicable to a
 22 family of the size involved.

23 (b) SLIDING SCALE FOR REMAINDER.—

24 (1) REQUIRED COINSURANCE.—The State plan
 25 shall impose cost sharing in the form of coinsurance

1 (based on the amount paid under the State plan for
2 a service)—

3 (A) at a rate of 10 percent for individuals
4 with disabilities with income not less than 150
5 percent, and less than 175 percent, of such offi-
6 cial poverty line (as so applied);

7 (B) at a rate of 15 percent for such indi-
8 viduals with income not less than 175 percent,
9 and less than 225 percent, of such official pov-
10 erty line (as so applied);

11 (C) at a rate of 25 percent for such indi-
12 viduals with income not less than 225 percent,
13 and less than 275 percent, of such official pov-
14 erty line (as so applied);

15 (D) at a rate of 30 percent for such indi-
16 viduals with income not less than 275 percent,
17 and less than 325 percent, of such official pov-
18 erty line (as so applied);

19 (E) at a rate of 35 percent for such indi-
20 viduals with income not less than 325 percent,
21 and less than 400 percent, of such official pov-
22 erty line (as so applied); and

23 (F) at a rate of 40 percent for such indi-
24 viduals with income equal to at least 400 per-
25 cent of such official poverty line (as so applied).

1 (2) REQUIRED ANNUAL DEDUCTIBLE.—The
2 State plan shall impose cost sharing in the form of
3 an annual deductible—

4 (A) of \$100 for individuals with disabilities
5 with income not less than 150 percent, and less
6 than 175 percent, of such official poverty line
7 (as so applied);

8 (B) of \$200 for such individuals with in-
9 come not less than 175 percent, and less than
10 225 percent, of such official poverty line (as so
11 applied);

12 (C) of \$300 for such individuals with in-
13 come not less than 225 percent, and less than
14 275 percent, of such official poverty line (as so
15 applied);

16 (D) of \$400 for such individuals with in-
17 come not less than 275 percent, and less than
18 325 percent, of such official poverty line (as so
19 applied);

20 (E) of \$500 for such individuals with in-
21 come not less than 325 percent, and less than
22 400 percent, of such official poverty line (as so
23 applied); and

1 (F) of \$600 for such individuals with in-
2 come equal to at least 400 percent of such offi-
3 cial poverty line (as so applied).

4 (c) RECOMMENDATION OF THE SECRETARY.—The
5 Secretary shall make recommendations to the States as
6 to how to reduce cost-sharing for individuals with extraor-
7 dinary out-of-pocket costs for whom the cost-sharing pro-
8 visions of this section could jeopardize their ability to take
9 advantage of the services offered under this subtitle. The
10 Secretary shall establish a methodology for reducing the
11 cost-sharing burden under this subtitle for individuals
12 with exceptionally high out-of-pocket costs.

13 (d) DETERMINATION OF INCOME FOR PURPOSES OF
14 COST SHARING.—The State plan shall specify the process
15 to be used to determine the income of an individual with
16 disabilities for purposes of this section. Such standards
17 shall include a uniform Federal definition of income and
18 any allowable deductions from income.

19 **SEC. 2105. QUALITY ASSURANCE AND SAFEGUARDS.**

20 (a) QUALITY ASSURANCE.—

21 (1) IN GENERAL.—The State plan shall specify
22 how the State will ensure and monitor the quality of
23 services.

24 (2) ISSUANCE OF REGULATIONS.—Not later
25 than 1 year after the date of enactment of this sub-

1 title, the Secretary shall issue regulations imple-
2 menting the quality provisions of this subsection.

3 (b) FEDERAL STANDARDS.—The State plan shall ad-
4 here to Federal quality standards in the following areas:

5 (1) Case review of a specified sample of client
6 records.

7 (2) The mandatory reporting of abuse, neglect,
8 or exploitation.

9 (3) The development of a registry of provider
10 agencies or home care workers and consumer di-
11 rected providers of personal assistance services
12 against whom any complaints have been sustained,
13 which shall be available to the public.

14 (4) Sanctions to be imposed on States or pro-
15 viders, including disqualification from the program,
16 if minimum standards are not met.

17 (5) Surveys of client satisfaction.

18 (6) State optional training programs for infor-
19 mal caregivers.

20 (c) CLIENT ADVOCACY.—The State plan shall provide
21 that the State will expend the amount allocated under sec-
22 tion 2108(b)(2) for client advocacy activities. The State
23 may use such funds to augment the budgets of the long-
24 term care ombudsman (under the Older Americans Act of
25 1965) and the Protection and Advocacy Agency (under the

1 Developmental Disabilities Assistance and Bill of Rights
2 Act) or may establish a separate and independent client
3 advocacy office to administer a new program designed to
4 advocate for client rights.

5 **SEC. 2106. ADVISORY GROUPS.**

6 (a) FEDERAL ADVISORY GROUP.—

7 (1) ESTABLISHMENT.—The Secretary shall es-
8 tablish an advisory group, to advise the Secretary
9 and States on all aspects of the program under this
10 subtitle.

11 (2) COMPOSITION.—The group shall be com-
12 posed of individuals with disabilities and their rep-
13 resentatives, providers, Federal and State officials,
14 and local community implementing agencies. A ma-
15 jority of its members shall be individuals with dis-
16 abilities and their representatives.

17 (b) STATE ADVISORY GROUPS.—

18 (1) IN GENERAL.—Each State plan shall pro-
19 vide for the establishment and maintenance of an
20 advisory group to advise the State on all aspects of
21 the State plan under this subtitle.

22 (2) COMPOSITION.—Members of each advisory
23 group shall be appointed by the Governor (or other
24 chief executive officer of the State) and shall include
25 individuals with disabilities and their representa-

1 tives, providers, State officials, and local community
2 implementing agencies. A majority of its members
3 shall be individuals with disabilities and their rep-
4 resentatives. The members of the advisory group
5 shall be selected from those nominated as described
6 in paragraph (3).

7 **SEC. 2107. PAYMENTS TO STATES.**

8 (a) IN GENERAL.—Subject to section 2101(a)(9)(C)
9 (relating to limitation on payment for administrative
10 costs), the Secretary, in accordance with the Cash Man-
11 agement Improvement Act, shall authorize payment to
12 each State with a plan approved under this subtitle, for
13 each quarter (beginning on or after January 1, 1998),
14 from its allotment under section 2108(b), an amount equal
15 to—

16 (1)(A) if the amount demonstrated by State
17 claims to have been expended during the year for
18 home and community-based services under the plan
19 for individuals with disabilities does not exceed 20
20 percent of the amount allotted to the State under
21 section 2108(b), 100 percent of the amount dem-
22 onstrated by State claims to have been expended
23 during the quarter for such services for such individ-
24 uals; or

1 (B) for the amount demonstrated by State
2 claims to have been expended during the year for
3 home and community-based services under the plan
4 for individuals with disabilities that exceeds 20 per-
5 cent of the amount allotted to the State under sec-
6 tion 2108(b), the Federal home and community-
7 based services matching percentage (as defined in
8 subsection (b)) of such amount; plus

9 (2) an amount equal to 90 percent of the
10 amount demonstrated by the State to have been ex-
11 pended during the quarter for quality assurance ac-
12 tivities under the plan; plus

13 (3) an amount equal to 90 percent of amount
14 expended during the quarter under the plan for ac-
15 tivities (including preliminary screening) relating to
16 determination of eligibility and performance of needs
17 assessment; plus

18 (4) an amount equal to 90 percent (or, begin-
19 ning with quarters in fiscal year 2004, 75 percent)
20 of the amount expended during the quarter for the
21 design, development, and installation of mechanical
22 claims processing systems and for information re-
23 trieval; plus

24 (5) an amount equal to 50 percent of the re-
25 mainder of the amounts expended during the quar-

1 ter as found necessary by the Secretary for the prop-
2 er and efficient administration of the State plan.

3 (b) FEDERAL HOME AND COMMUNITY-BASED SERV-
4 ICES MATCHING PERCENTAGE.—In subsection (a), the
5 term “Federal home and community-based services
6 matching percentage” means, with respect to a State, the
7 State’s Federal medical assistance percentage (as defined
8 in section 1905(b) of the Social Security Act) increased
9 by 15 percentage points, except that the Federal home and
10 community-based services matching percentage shall in no
11 case be more than 95 percent.

12 (c) PAYMENTS ON ESTIMATES WITH RETROSPECTIVE
13 ADJUSTMENTS.—The method of computing and making
14 payments under this section shall be as follows:

15 (1) The Secretary shall, prior to the beginning
16 of each quarter, estimate the amount to be paid to
17 the State under subsection (a) for such quarter,
18 based on a report filed by the State containing its
19 estimate of the total sum to be expended in such
20 quarter, and such other information as the Secretary
21 may find necessary.

22 (2) From the allotment available therefore, the
23 Secretary shall provide for payment of the amount
24 so estimated, reduced or increased, as the case may
25 be, by any sum (not previously adjusted under this

1 section) by which the Secretary finds that the esti-
 2 mate of the amount to be paid the State for any
 3 prior period under this section was greater or less
 4 than the amount which should have been paid.

5 (d) APPLICATION OF RULES REGARDING LIMITA-
 6 TIONS ON PROVIDER-RELATED DONATIONS AND HEALTH
 7 CARE RELATED TAXES.—The provisions of section
 8 1903(w) of the Social Security Act shall apply to pay-
 9 ments to States under this section in the same manner
 10 as they apply to payments to States under section 1903(a)
 11 of such Act.

12 (e) FAILURE TO COMPLY WITH STATE PLAN.—If a
 13 State furnishing home and community-based services
 14 under this subtitle fails to comply with the State plan ap-
 15 proved under this subtitle, the Secretary may either re-
 16 duce the Federal matching rates available to the State
 17 under subsection (a) or withhold an amount of funds de-
 18 termined appropriate by the Secretary from any payment
 19 to the State under this section.

20 **SEC. 2108. APPROPRIATIONS; ALLOTMENTS TO STATES.**

21 (a) APPROPRIATIONS.—

22 (1) FISCAL YEARS 1998 THROUGH 2003.—Sub-
 23 ject to paragraph (5)(C), for purposes of this sub-
 24 title, the appropriation authorized under this subtitle

1 for each of fiscal years 1997 through 2004 is the
2 following:

3 (A) For fiscal year 1997, \$3,900,000,000.

4 (B) For fiscal year 1998, \$6,800,000,000.

5 (C) For fiscal year 1999, \$9,600,000,000.

6 (D) For fiscal year 2000,
7 \$12,900,000,000.

8 (E) For fiscal year 2001,
9 \$16,400,000,000.

10 (F) For fiscal year 2002,
11 \$23,400,000,000.

12 (G) For fiscal year 2003,
13 \$31,100,000,000.

14 (H) For fiscal year 2004,
15 \$33,600,000,000.

16 (2) SUBSEQUENT FISCAL YEARS.—For pur-
17 poses of this subtitle, the appropriation authorized
18 for State plans under this subtitle for each fiscal
19 year after fiscal year 2003 is the appropriation au-
20 thorized under this subsection for the preceding fis-
21 cal year multiplied by—

22 (A) a factor (described in paragraph (3))
23 reflecting the change in the consumer price
24 index for the fiscal year, and

1 (B) a factor (described in paragraph (4))
2 reflecting the change in the number of individ-
3 uals with disabilities for the fiscal year.

4 (3) CPI INCREASE FACTOR.—For purposes of
5 paragraph (2)(A), the factor described in this para-
6 graph for a fiscal year is the ratio of—

7 (A) the annual average index of the
8 consumer price index for the preceding fiscal
9 year, to—

10 (B) such index, as so measured, for the
11 second preceding fiscal year.

12 (4) DISABLED POPULATION FACTOR.—For pur-
13 poses of paragraph (2)(B), the factor described in
14 this paragraph for a fiscal year is 100 percent plus
15 (or minus) the percentage increase (or decrease)
16 change in the disabled population of the United
17 States (as determined for purposes of the most re-
18 cent update under subsection (b)(3)(D)).

19 (5) ADDITIONAL FUNDS DUE TO MEDICAID
20 OFFSETS.—

21 (A) IN GENERAL.—Each participating
22 State must provide the Secretary with informa-
23 tion concerning offsets and reductions in the
24 medicaid program resulting from home and
25 community-based services provided disabled in-

1 dividuals under this subtitle, that would have
2 been paid for such individuals under the State
3 medicaid plan but for the provision of similar
4 services under the program under this subtitle.
5 At the time a State first submits its plan under
6 this subtitle and before each subsequent fiscal
7 year (through fiscal year 2005), the State also
8 must provide the Secretary with such budgetary
9 information (for each fiscal year through fiscal
10 year 2005), as the Secretary determines to be
11 necessary to carry out this paragraph.

12 (B) REPORTS.—Each State with a pro-
13 gram under this subtitle shall submit such re-
14 ports to the Secretary as the Secretary may re-
15 quire in order to monitor compliance with sub-
16 paragraph (A). The Secretary shall specify the
17 format of such reports and establish uniform
18 data reporting elements.

19 (C) ADJUSTMENTS TO APPROPRIATION.—

20 (i) IN GENERAL.—For each fiscal year
21 (beginning with fiscal year 1998 and end-
22 ing with fiscal year 2004) and based on a
23 review of information submitted under sub-
24 paragraph (A), the Secretary shall deter-
25 mine the amount by which the appropria-

1 tion authorized under subsection (a) will
2 increase. The amount of such increase for
3 a fiscal year shall be limited to the reduc-
4 tion in Federal expenditures of medical as-
5 sistance (as determined by Secretary) that
6 would have been made under part A of
7 title XIX for home and community based
8 services for disabled individuals but for the
9 provision of similar services under the pro-
10 gram under this subtitle.

11 (ii) ANNUAL PUBLICATION.—The Sec-
12 retary shall publish before the beginning of
13 such fiscal year, the revised appropriation
14 authorized under this subsection for such
15 fiscal year.

16 (D) CONSTRUCTION.—Nothing in this sub-
17 section shall be construed as requiring States to
18 determine eligibility for medical assistance
19 under the State medicaid plan on behalf of indi-
20 viduals receiving assistance under this subtitle.

21 (b) ALLOTMENTS TO STATES.—

22 (1) IN GENERAL.—The Secretary shall allot the
23 amounts available under the appropriation author-
24 ized for the fiscal year (specified in subsection (a))
25 to the States with plans approved under this subtitle

1 in accordance with an allocation formula developed
 2 by the Secretary which takes into account—

3 (A) the percentage of the total number of
 4 individuals with disabilities in all States that re-
 5 side in a particular State;

6 (B) the per capita costs of furnishing home
 7 and community-based services to individuals
 8 with disabilities in the State; and

9 (C) the percentage of all individuals with
 10 incomes at or below 150 percent of the official
 11 poverty line (as described in section 2104(a)(2))
 12 in all States that reside in a particular State.

13 (2) ALLOCATION FOR CLIENT ADVOCACY AC-
 14 TIVITIES.—Each State with a plan approved under
 15 this subtitle shall allocate one-half of one percent of
 16 the State's total allotment under paragraph (1) for
 17 client advocacy activities as described in section
 18 2105(c).

19 (3) NO DUPLICATE PAYMENT.—No payment
 20 may be made to a State under this section for any
 21 services provided to an individual to the extent that
 22 the State received payment for such services under
 23 section 1903(a) of the Social Security Act.

24 (4) REALLOCATIONS.—Any amounts allotted to
 25 States under this subsection for a year that are not

1 expended in such year shall remain available for
 2 State programs under this subtitle and may be re-
 3 allocated to States as the Secretary determines ap-
 4 propriate.

5 (c) STATE ENTITLEMENT.—This subtitle constitutes
 6 budget authority in advance of appropriations Acts, and
 7 represents the obligation of the Federal Government to
 8 provide for the payment to States of amounts described
 9 in subsection (a).

10 **Subtitle B—Life Care**

11 **SEC. 2201. SHORT TITLE.**

12 This subtitle may be cited as the “Life Care Act”.

13 **SEC. 2202. LIFE CARE: PUBLIC INSURANCE PROGRAM FOR** 14 **NURSING HOME CARE.**

15 The Public Health Service Act is amended by adding
 16 at the end thereof the following new title:

17 **“TITLE XXVII—LIFE CARE: PUB-** 18 **LIC INSURANCE PROGRAM** 19 **FOR NURSING HOME CARE**

20 **“SEC. 2701. ESTABLISHMENT OF VOLUNTARY LONG-TERM** 21 **CARE INSURANCE PROGRAM.**

22 “The Secretary shall establish a voluntary insurance
 23 program for individuals 35 years of age and over to cover
 24 the nursing home stays of such individuals. The Secretary

1 shall establish a process for enrollment in the Life Care
2 program.

3 **“SEC. 2702. BENEFITS.**

4 “(a) IN GENERAL.—

5 “(1) ELIGIBILITY FOR COVERAGE.—Subject to
6 subsection (c), an individual who meets the eligibility
7 criteria prescribed in section 2703 shall be eligible
8 under the program established under this title for
9 coverage for necessary services described in sub-
10 section (b) (in the amounts described in subsection
11 (c)) that are provided to the individual by a nursing
12 facility while the individual is an inpatient of the
13 facility.

14 “(2) NONFORFEITURE.—The Secretary shall
15 establish standards to ensure the nonforfeiture of
16 benefits for which premiums have been paid.

17 “(b) TYPES.—Coverage may be provided under this
18 title for—

19 “(1) nursing care provided by or under the su-
20 pervision of a registered professional nurse;

21 “(2) physical, occupational, or speech therapy
22 furnished by a facility or by others under arrange-
23 ments with a facility;

24 “(3) medical social work services;

1 “(4) drug, biological, supply, appliance, and
2 equipment for use in the facility, that is ordinarily
3 furnished by the facility for the care and treatment
4 of an inpatient;

5 “(5) such other services necessary to the func-
6 tioning of a patient, including personal care and as-
7 sistance with activities of daily living, as are gen-
8 erally provided by a nursing home facility; and

9 “(6) with respect to the initial 6 months of cov-
10 ered residence in a nursing facility, such room and
11 board costs as are not covered by beneficiary
12 copayment.

13 “(c) COVERAGE AMOUNT.—

14 “(1) IN GENERAL.—The amount of coverage
15 provided with respect to an eligible individual for the
16 services described in subsection (b) shall, based on
17 an election made by the individual, not exceed
18 \$30,000, \$60,000, or \$90,000 over the lifetime of
19 the eligible individual. Such amounts shall be ad-
20 justed by the Secretary to reflect increases in the
21 Consumer Price Index.

22 “(2) ASSET PROTECTION.—An eligible individ-
23 ual shall be entitled to the asset protection provided
24 under section 2708.

1 “(d) PAYMENT.—Amounts provided under this title
2 with respect to an eligible individual for the services de-
3 scribed in subsection (b) shall be paid from the general
4 fund of the Treasury of the United States.

5 “(e) RESIDENTIAL CARE FACILITIES.—The Sec-
6 retary shall consider the feasibility of making payments
7 under this title for services delivered in residential care
8 facilities. Not later than 2 years after the date of enact-
9 ment of this Act, the Secretary shall report the findings
10 of the Secretary to the Congress with respect to the fea-
11 sibility of making such payments.

12 **“SEC. 2703. ELIGIBILITY.**

13 “(a) IN GENERAL.—An individual shall be eligible for
14 benefits under this title if—

15 “(1) the individual—

16 “(A) is a legal resident of the United
17 States and has elected coverage under sub-
18 section (c); and

19 “(B) has been determined by a Screening
20 Agency through a screening process (conducted
21 in accordance with section 2707)—

22 “(i)(I) to require hands-on or standby
23 assistance, supervision, or cueing (as de-
24 fined in regulations) to perform three or
25 more activities of daily living; or

1 “(II) to require hands-on or standby
2 assistance, supervision, or cueing with at
3 least such instrumental activity (or activi-
4 ties) of daily living related to cognitive or
5 mental impairment as the Secretary speci-
6 fies; or

7 “(III) to display symptoms of one or
8 more serious behavioral problems (that is
9 on a list of such problems specified by the
10 Secretary) which create a need for super-
11 vision to prevent harm to self or others; or

12 “(IV) has achieved a score, on a
13 standard mental status protocol (or proto-
14 cols) appropriate for measuring the indi-
15 vidual’s particular condition specified by
16 the Secretary, that indicates either severe
17 cognitive impairment or severe mental im-
18 pairment, or both; and

19 “(ii) to require such assistance, super-
20 vision, or cueing over a period of at least
21 90 days; and

22 “(2)(A) the individual has filed an application
23 for such benefits, and is in need of, benefits covered
24 under this title; or

1 “(B) the legal guardian of the individual has
2 filed an application on behalf of an individual who
3 is in need of benefits covered under this title; or

4 “(C) the representative of an individual who is
5 cognitively impaired and who is in need of benefits
6 covered under this title has filed an application on
7 behalf of the individual.

8 “(b) CURRENT INDIVIDUALS.—An individual who is
9 in a hospital or nursing home on the date of the enroll-
10 ment of the individual in the program established under
11 this title shall be ineligible for coverage under this section
12 until the individual’s first spell of illness beginning after
13 such date.

14 “(c) ELECTION OF COVERAGE.—

15 “(1) IN GENERAL.—Subject to this subsection,
16 an individual shall have the option to purchase cov-
17 erage under this title when the individual is 35 years
18 of age, 45 years of age, 55 years of age, or 65 years
19 of age.

20 “(2) INITIAL YEAR.—During the 1-year period
21 beginning on the date on which final regulations
22 that implement this title are issued, an individual
23 who is 35 years of age or older shall be eligible to
24 purchase insurance under this title, except that such

1 an individual shall not be eligible to purchase such
2 insurance—

3 “(A) while confined to a hospital or nurs-
4 ing home;

5 “(B) within the 6-month period after the
6 individual’s confinement in a nursing home; or

7 “(C) within the 90-day period after the in-
8 dividual’s confinement in a hospital.

9 Individuals described in the matter preceding sub-
10 paragraph (A) shall become eligible to receive bene-
11 fits under this title on the expiration of the 3-year
12 period beginning on the date such individuals pur-
13 chase insurance under this title.

14 “(3) EXTENSION BEYOND INITIAL YEAR.—If an
15 individual is confined to a nursing home or hospital
16 during a period that extends beyond the first year
17 after the effective date of this title, an individual
18 shall be eligible to enroll in the program established
19 by this title during the 60-day period beginning after
20 the individual’s spell of illness.

21 “(4) SUBSEQUENT YEARS.—During years sub-
22 sequent to the 1-year period referred to in para-
23 graph (2), an individual shall be eligible to purchase
24 insurance under this title within 6 months of the
25 35th, 45th, 55th, or 65th birthday of the individual.

1 “(5) ACTIVATION OF BENEFITS.—To receive
2 coverage under the insurance program established by
3 this title, an individual shall have purchased such
4 coverage not later than 1 month prior to admission
5 to a nursing facility, unless the reason for the need
6 of services is a result of an accident or stroke subse-
7 quent to the date that such individual enrolled for
8 coverage under this title.

9 “(d) PUBLIC EDUCATION.—In the 12 months preced-
10 ing the initial enrollment period, the Secretary shall, either
11 directly or through grants and contracts, conduct a public
12 service and education campaign designed to inform poten-
13 tially eligible individuals as to the nature of the benefits
14 and the limited enrollment period. In conducting such
15 campaigns the Secretary shall make information available
16 to individuals through the open enrollment process for ob-
17 taining health care benefits under this Act.

18 **“SEC. 2704. PREMIUM RATES.**

19 “(a) IN GENERAL.—The Secretary shall determine
20 one premium rate for individuals electing to purchase cov-
21 erage under this title at age 35 (or between the ages of
22 35 and 44 during the initial enrollment period), a separate
23 rate for those individuals who elect coverage at age 45
24 (or between the ages of 45 and 54 during the initial enroll-
25 ment period), a separate rate for those individuals who

1 elect such coverage at age 55 (or between that ages of
2 55 and 64 during the initial enrollment period), and a sep-
3 arate rate for those individuals who elect such coverage
4 at age 65 (or at age 65 and over during the initial enroll-
5 ment period). During the initial enrollment period, the
6 Secretary shall establish actuarially fair, age-rated pre-
7 miums for persons age 65 and over.

8 “(b) REVISION.—The Secretary shall revise premium
9 rates annually to increase such rates to reflect the amount
10 of the increase in the cost of living adjustment with re-
11 spect to benefits under title II of the Social Security Act.

12 “(c) RATES.—In developing premium rates under the
13 program established under this title, the Secretary shall
14 establish rates that are expected to cover 100 percent of
15 the reimbursement amount provided under this title for
16 nursing home stays for those individuals enrolled in the
17 program.

18 “(d) WAIVER.—An individual electing to purchase
19 coverage under this title shall not be required to pay pre-
20 miums during any period in which such individual is re-
21 ceiving benefits under this title.

22 “(e) PAYMENT.—Premiums shall be paid under this
23 section into the general fund of the Treasury of the United
24 States.

1 **“SEC. 2705. QUALIFIED SERVICE PROVIDERS.**

2 “(a) IN GENERAL.—To be considered as a covered
3 nursing home service under this title, such service must
4 have been provided by a qualified service provider.

5 “(b) TYPES.—A provider shall be considered a quali-
6 fied service provider under this title if the provider is a
7 nursing facility that is certified by the State and meets
8 the requirements of this title and any other standards es-
9 tablished by the Secretary by regulation for the safe and
10 efficient provision of services covered under this title.

11 **“SEC. 2706. REIMBURSEMENT.**

12 “(a) AMOUNT.—Monthly reimbursement for nursing
13 facility services under this title shall equal 65 percent (or
14 during the initial 6 months of coverage, 80 percent) of
15 the amount the Secretary determines to be reasonable and
16 appropriate to cover the cost of care provided under this
17 title.

18 “(b) PROSPECTIVE PAYMENT.—To the extent fea-
19 sible, the Secretary shall establish a prospective payment
20 mechanism for payment for nursing home services under
21 this title that takes into account the expected resource uti-
22 lization of individual patients based on their degree of dis-
23 ability, the methodology recommended for reimbursement
24 of skilled nursing facilities under title XVIII of the Social
25 Security Act, and other factors determining service re-
26 quirements.

1 “(c) ROOM AND BOARD PAYMENT.—An individual
2 receiving benefits under this program shall be responsible
3 for the payment of an amount for room and board that
4 is equal to—

5 “(1) with respect to the initial 6 months of resi-
6 dence in a nursing facility, 20 percent of the average
7 per diem rate paid by the Secretary to nursing facili-
8 ties receiving reimbursement under this title; and

9 “(2) with respect to subsequent periods of resi-
10 dence, 35 percent of the average per diem rate paid
11 by the Secretary to nursing facilities receiving reim-
12 bursement under this title. Payments under sub-
13 sections (a) and (c) shall be considered payment in
14 full for services received under this section.

15 “(d) PRIORITY PAYERS.—Notwithstanding any other
16 provision of this title, reimbursement for nursing facility
17 services provided under this title to an individual shall,
18 to the extent available, be made under the Medicare pro-
19 gram, under Department of Veterans Affairs’ programs,
20 or under private insurance policies prior to reimbursement
21 under this title.

22 **“SEC. 2707. LONG-TERM CARE SCREENING AGENCY.**

23 “(a) ESTABLISHMENT.—The Secretary shall contract
24 with entities to act as Long-Term Care Screening Agen-
25 cies (hereafter referred to in this title as the ‘Screening

1 Agency') for each designated area of a State. It shall be
2 the responsibility of such agency to assess the eligibility
3 of individuals residing in the geographic jurisdiction of the
4 Agency, for services provided under this title according to
5 the requirements of this title and regulations prescribed
6 by the Secretary. In entering into such contracts, the Sec-
7 retary shall give preference to State governmental entities
8 and private nonprofit agencies.

9 “(b) ELIGIBILITY.—The Screening Agency shall de-
10 termine the eligibility of an individual under this title
11 based on the results of a preliminary telephone interview
12 or written questionnaire (completed by the applicant, by
13 the caregiver of the applicant, or by the legal guardian
14 or representative of the applicant) that shall be validated
15 through the use of a screening tool administered in person
16 to each applicant determined eligible through initial tele-
17 phone or written questionnaire interviews not later than
18 15 days from the date on which such individual initially
19 applied for services under this title.

20 “(c) QUESTIONNAIRES AND SCREENING TOOLS.—

21 “(1) IN GENERAL.—The Secretary shall estab-
22 lish a telephone or written questionnaire and a
23 screening tool to be used by the Screening Agency
24 to determine the eligibility of an individual for serv-
25 ices under this title consistent with requirements of

1 this title and the standards established by the Sec-
2 retary by regulation.

3 “(2) QUESTIONNAIRES.—The questionnaire
4 shall include questions about the functional impair-
5 ment and mental status of an individual and other
6 criteria that the Secretary shall prescribe by regula-
7 tion.

8 “(3) SCREENING TOOLS.—The screening tool
9 should measure functional impairment caused by
10 physical or cognitive conditions as well as informa-
11 tion concerning cognition disability, behavioral prob-
12 lems (such as wandering or abusive and aggressive
13 behavior), and any other criteria that the Secretary
14 shall prescribe by regulation. The screening tool
15 shall be administered in person.

16 “(d) NOTIFICATION.—Not later than 15 days after
17 the date on which an individual initially applied for serv-
18 ices under this title (by telephone or written question-
19 naire), the Screening Agency shall notify such individual
20 that such individual is not eligible for benefits, or that
21 such individuals must schedule an in-person screening to
22 determine final eligibility for benefits under this title. The
23 Screening Agency shall notify such individual of its final
24 decision not later than 2 working days after the in-person
25 screening.

1 “(e) IN-PERSON SCREENING.—An individual (or the
2 legal guardian or representative of such individual) whose
3 application for benefits under this title is denied on the
4 basis of information provided through a telephone or writ-
5 ten questionnaire, shall be notified of such individual’s
6 right to an in-person screening by a nurse or appropriate
7 health care professionals.

8 “(f) APPEALS.—The Secretary shall establish a
9 mechanism for hearings and appeals in cases in which in-
10 dividuals contest the eligibility findings of the Screening
11 Agency.

12 “(g) PAYMENT.—

13 “(1) PAYMENT FOR SCREENING.—The Screen-
14 ing Agency may require payment from individuals
15 only in accordance with standards established by the
16 Secretary.

17 “(2) NO PAYMENT FOR POOREST.—The Screen-
18 ing Agency may not require payment for individuals
19 with incomes of less than 150 percent of the official
20 poverty line.

21 **“SEC. 2708. ASSET PROTECTION.**

22 “Notwithstanding any other provision of law, the as-
23 sets an eligible individual may retain and be determined
24 eligible for nursing facility benefits, including payments of
25 room and board under this title, under State Medicaid

1 programs (in accordance with section 1902(a)(10)) shall
 2 be increased by the amount of coverage (\$30,000,
 3 \$60,000, or \$90,000) elected under section 2702.

4 **“SEC. 2709. RELATION TO PRIVATE INSURANCE.**

5 “(a) IN GENERAL.—Except as provided in subsection
 6 (b), an insurer may not offer a long-term care insurance
 7 policy to an individual who has purchased coverage under
 8 this title if the coverage under such policy duplicates the
 9 coverage provided under this title.

10 “(b) DEVELOPMENT OF STANDARD PACKAGES.—The
 11 Secretary shall develop standard long-term care insurance
 12 benefits packages that insurers may offer to insured indi-
 13 viduals under this title. Such packages shall provide cov-
 14 erage for benefits that compliment, but do not duplicate,
 15 those covered under this title.

16 **“SEC. 2710. DEFINITIONS.**

17 “As used in this title:

18 “(1) NURSING FACILITY.—The term ‘nursing
 19 facility’ means—

20 “(A) a skilled nursing facility (as defined
 21 in section 1819(a) of the Social Security Act);
 22 or

23 “(B) a facility that is a nursing fa-
 24 cility (as defined in section 1919(a) of such
 25 Act) which meets the requirements of section

1 1819(b)(4)(C) of such Act (relating to nursing
2 care).

3 “(2) SPELL OF ILLNESS.—The term ‘spell of
4 illness’ means a period of consecutive days beginning
5 with the first day on which an individual is fur-
6 nished services as an inpatient in a hospital or nurs-
7 ing facility and ending with the close of the first 6
8 consecutive months thereafter during which the indi-
9 vidual is no longer an inpatient of a nursing facility,
10 or 90 days after the individual is no longer an inpa-
11 tient in a hospital.

12 **“SEC. 2711. REPORTS.**

13 “(a) IN GENERAL.—Prior to the promulgation of reg-
14 ulations implementing this title, the Secretary shall report
15 to Congress on—

16 “(1) the actuarially-sound premium rates to be
17 used in the implementation of this Act, including
18 whether the premiums and interest accrued thereon
19 will cover 100 percent of the benefits paid out, and
20 whether Federal funds will be required to support
21 the payment of benefits;

22 “(2) an assessment of the impact of such pre-
23 mium rates on the affordability of coverage under
24 this Act;

1 “(3) a projected enrollment of individuals by
2 age category; and

3 “(4) an estimate of current and projected en-
4 rollment of individuals, by age category in coverage
5 under private long-term care insurance.

6 “(b) LIFE CARE REPORT.—Not later than 2 years
7 after the promulgation of regulations implementing this
8 title, the Secretary shall report to Congress on the follow-
9 ing aspects of the Life Care Act:

10 “(1) The current and projected premium rates.

11 “(2) The current and projected enrollment of
12 individuals, by age category and an estimate of cur-
13 rent and projected enrollment of individuals by age
14 category in private long-term care insurance.

15 “(3) The projected use of benefits and the im-
16 pact of use on premium rates.

17 “(4) An assessment of the impact of projected
18 premium rates on the affordability of coverage under
19 this Act.

20 “(c) RECOMMENDATIONS.—The Secretary shall make
21 recommendations to Congress regarding necessary revi-
22 sions to the Life Care Act as a result of the findings pro-
23 vided in the reports submitted under this section.”.

1 **Subtitle C—Sense of the Committee**
2 **with Regard to Prescription Drugs**

3 **SEC. 2301. SENSE OF THE COMMITTEE WITH REGARD TO**
4 **PRESCRIPTION DRUGS.**

5 It is the Sense of the Committee on Labor and
6 Human Resources of the Senate that when the Affordable
7 Health Care for All Americans Act is enacted it should
8 include a provision for coverage of outpatient prescription
9 drugs under the medicare program comparable to the pro-
10 vision included in S. 1757, the Health Security Act (as
11 introduced in the 103rd Congress) and providing for a
12 drug deductible of not more than \$200, coinsurance of not
13 more than 20 percent, and an out-of-pocket limit of not
14 more than \$1,000.

1 **TITLE III—PUBLIC HEALTH**
 2 **INITIATIVES**

3 **Subtitle A—Workforce Priorities**
 4 **Under Federal Payments**

5 **PART 1—INSTITUTIONAL COSTS OF GRADUATE**
 6 **MEDICAL EDUCATION; WORKFORCE PRIORITIES**

7 **Subpart A—National Council Regarding Workforce**
 8 **Priorities**

9 **SEC. 3001. NATIONAL COUNCIL ON GRADUATE MEDICAL**
 10 **EDUCATION.**

11 (a) IN GENERAL.—There is established within the
 12 Department of Health and Human Services a council to
 13 be known as the National Council on Graduate Medical
 14 Education.

15 (b) DUTIES.—The Secretary shall carry out subpart
 16 B acting through the National Council.

17 (c) COMPOSITION.—

18 (1) IN GENERAL.—The membership of the Na-
 19 tional Council shall include between 12 and 18 indi-
 20 viduals who are appointed to the Council from
 21 among individuals who are not officers or employees
 22 of the United States. Such individuals shall be ap-
 23 pointed by the Secretary, and shall include individ-
 24 uals from each of the following categories:

1 (A) Consumers of health care services, at
2 least one of whom resides in a rural area.

3 (B) Physicians who are faculty members of
4 medical schools.

5 (C) Physicians in private practice who are
6 not physicians described in subparagraph (B).

7 (D) Officers or employees of regional and
8 corporate health alliances.

9 (E) Officers or employees of health care
10 plans that participate in such alliances.

11 (F) Executives of teaching hospitals.

12 (G) Nurses.

13 (H) Primary care physicians, at least one
14 of whom practices in a rural area.

15 (I) Such other individuals as the Secretary
16 determines to be appropriate.

17 (2) EX OFFICIO MEMBERS; OTHER FEDERAL
18 OFFICERS OR EMPLOYEES.—The membership of the
19 National Council shall include individuals designated
20 by the Secretary to serve as members of the Council
21 from among Federal officers or employees who are
22 appointed by the President, or by the Secretary or
23 other Federal officers who are appointed by the
24 President with the advice and consent of the Senate.

1 (d) CHAIR.—The Secretary shall, from among mem-
 2 bers of the National Council appointed under subsection
 3 (c)(1), designate an individual to serve as the Chair of
 4 the Council.

5 (e) DEFINITIONS.—For purposes of this subtitle:

6 (1) The term “academic health center” means
 7 an entity defined in section 3051(c)(1).

8 (2) The term “medical school” means a school
 9 of medicine (as defined in section 799 of the Public
 10 Health Service Act) or a school of osteopathic medi-
 11 cine (as defined in such section).

12 (3) The term “National Council” means the
 13 council established in subsection (a).

14 (f) CONFORMING AMENDMENT REPEALING THE
 15 COUNCIL ON GRADUATE MEDICAL EDUCATION
 16 (COGME).—Effective on the date of the first meeting of
 17 the National Council, section 30 of the Health Professions
 18 Education Extension Amendments of 1992 (Public Law
 19 102–408) is repealed.

20 **Subpart B—Authorized Positions in Specialty**

21 **Training**

22 **SEC. 3011. COOPERATION REGARDING APPROVED PHYSI-** 23 **CIAN TRAINING PROGRAMS.**

24 (a) IN GENERAL.—With respect to an approved phy-
 25 sician training program in a medical specialty, a funding

1 agreement with a qualified applicant for payments under
 2 section 3031 for a calendar year is that the qualified appli-
 3 cant will ensure that the number of individuals enrolled
 4 in the program in the subsequent academic year is in ac-
 5 cordance with this subpart.

6 (b) DEFINITIONS.—

7 (1) APPROVED PROGRAM.—For purposes of this
 8 subtitle:

9 (A) The term “approved physician training
 10 program”, with respect to the medical speciality
 11 involved, means a residency or other post-
 12 graduate program that trains physicians and
 13 meets the following conditions:

14 (i) Participation in the program may
 15 be counted toward certification in the med-
 16 ical specialty.

17 (ii) The program is accredited by the
 18 Accreditation Council on Graduate Medical
 19 Education, or approved by the Council on
 20 Postgraduate Training of the American
 21 Osteopathic Association.

22 (B) The term “approved physician training
 23 program” includes any postgraduate program
 24 described in subparagraph (A) that provides
 25 health services in an ambulatory setting, with-

1 out regard to whether the program provides in-
2 patient hospital services.

3 (C) The term “approved physician training
4 program” includes any postgraduate program
5 described in subparagraph (A), whether oper-
6 ated by academic health centers, teaching hos-
7 pitals, multispecialty group practices, ambula-
8 tory care providers, prepaid health plans, or
9 other entities.

10 (D) The term “approved physician training
11 program” includes any postgraduate program
12 described in subparagraph (A) that provides fel-
13 lowship training in family medicine, general in-
14 ternal medicine or general pediatrics, and pro-
15 vides training for a faculty position in family
16 medicine, general medicine or general pediat-
17 rics.

18 (2) QUALIFIED APPLICANT; SUBPART DEFINI-
19 TION.—For purposes of this subpart, the term
20 “qualified applicant”, with respect to an academic
21 year, means an entity that trains individuals in an
22 approved physician program that receives payments
23 under subpart C for the calendar year in which the
24 academic year begins.

1 (3) OTHER DEFINITIONS.—For purposes of this
2 subtitle:

3 (A)(i) The term “academic year” means
4 the 1-year period beginning on July 1. The aca-
5 demic year beginning July 1, 1993, is academic
6 year 1993–94.

7 (ii) With respect to the funding agreement
8 described in subsection (a), the term “subse-
9 quent academic year” means the academic year
10 beginning July 1 of the calendar year for which
11 payments are to be made under the agreement.

12 (B) The term “funding agreement”, with
13 respect to payments under section 3031 to a
14 qualified applicant, means that the Secretary
15 may make the payments only if the qualified
16 applicant makes the agreement involved.

17 (C) The term “medical specialty” includes
18 all medical, surgical, and other physician spe-
19 cialties and subspecialties.

20 **SEC. 3012. ANNUAL AUTHORIZATION OF NUMBER OF SPE-**
21 **CIALTY POSITIONS; REQUIREMENTS REGARD-**
22 **ING PRIMARY HEALTH CARE.**

23 (a) ANNUAL AUTHORIZATION OF NUMBER OF POSI-
24 TIONS.—In the case of each medical specialty, the Na-
25 tional Council shall designate for each academic year the

1 number of individuals nationwide who are authorized to
2 be enrolled in eligible programs. The preceding sentence
3 is subject to subsection (c)(2).

4 (b) PRIMARY HEALTH CARE.—

5 (1) IN GENERAL.—Subject to paragraph (2), in
6 carrying out subsection (a) for an academic year, the
7 National Council shall ensure that, of the class of
8 training participants entering eligible programs for
9 academic year 2001–2002 or any subsequent aca-
10 demic year, the percentage of such class that com-
11 pletes eligible programs in primary health care is not
12 less than 55 percent (without regard to the academic
13 year in which the members of the class complete the
14 programs).

15 (2) RULE OF CONSTRUCTION.—The require-
16 ment of paragraph (1) regarding a percentage ap-
17 plies in the aggregate to training participants enter-
18 ing eligible programs for the academic year involved,
19 and not individually to any eligible program.

20 (c) DESIGNATIONS REGARDING 3-YEAR PERIODS.—

21 (1) DESIGNATION PERIODS.—For each medical
22 specialty, the National Council shall make the an-
23 nual designations under subsection (a) for periods of
24 3 academic years.

1 (2) INITIAL PERIOD.—The first designation pe-
2 riod established by the National Council after the
3 date of the enactment of this Act shall be the aca-
4 demic years 2001–2002 through 2003–2004.

5 (d) CERTAIN CONSIDERATIONS IN DESIGNATING AN-
6 NUAL NUMBERS.—

7 (1) IN GENERAL.—Factors considered by the
8 National Council in designating the annual number
9 of specialty positions for an academic year for a
10 medical specialty shall include the extent to which
11 there is a need for additional practitioners in the
12 specialty, as indicated by the following:

13 (A) The characteristics of diseases, dis-
14 orders, or health conditions treated, including—

15 (i) the incidence and prevalence (in
16 the general population and in various other
17 populations) of the diseases, disorders, or
18 other health conditions with which the spe-
19 cialty is concerned;

20 (ii) the intensity of care required for
21 each of these diseases, disorders, or health
22 conditions;

23 (iii) the relevant training received and
24 experience attained by primary care and
25 specialist physicians in caring for each of

1 these diseases, disorders, or health condi-
2 tions; and

3 (iv) when sufficient data becomes
4 available, the extent to which individuals
5 with certain diseases, disorders, or health
6 conditions have better health outcomes
7 when treated by health specialists than by
8 primary care physicians.

9 (B) The number of physicians who will be
10 practicing in the specialty in the academic year.

11 (C) The number of physicians who will be
12 practicing in the specialty at the end of the 5-
13 year period beginning on the first day of the
14 academic year.

15 (2) RECOMMENDATIONS OF PRIVATE ORGANIZA-
16 TIONS.—In designating the annual number of spe-
17 cialty positions for an academic year for a medical
18 specialty, the National Council shall consider the
19 recommendations of organizations representing phy-
20 sicians in the specialty, organizations representing
21 academic medicine, and the recommendations of or-
22 ganizations representing consumers of the services of
23 such physicians.

24 (3) TOTAL OF RESPECTIVE ANNUAL NUM-
25 BERS.—

1 (A) For academic year 2001–2002 and
2 subsequent academic years, the National Coun-
3 cil shall ensure that the total of the respective
4 annual numbers designated under subsection
5 (a) for an academic year is a total that—

6 (i) bears a relationship to the number
7 of individuals who graduated from medical
8 schools in the United States in the preced-
9 ing academic year; and

10 (ii) is consistent with the purposes of
11 this subpart.

12 (B) For each of the academic years 2001–
13 2002 through 2005–2006, the total determined
14 under subparagraph (A) shall be reduced by a
15 percentage determined by the National Council.

16 (e) INTERIM VOLUNTARY TARGETS.—

17 (1) ESTABLISHMENT.—Not later than July 1,
18 1998, the National Council shall establish targets
19 with respect to the aggregate number of individuals
20 enrolled in approved physician training programs for
21 each specialty to be achieved by the year 2001.

22 (2) VOLUNTARY COMPLIANCE.—Specialties that
23 meet and continue to be in compliance with the ag-
24 gregate targets established under paragraph (1), as
25 determined by the National Council, shall not be

1 subject to the mandatory allocation system described
2 in section 3013.

3 (3) MEASURE OF COMPLIANCE.—To be consid-
4 ered in compliance with the targets under paragraph
5 (2), a specialty shall demonstrate, not later than
6 July 1, 2000, that the number of individuals en-
7 rolled in approved physician training programs of
8 the specialty is not less than the number of individ-
9 uals enrolled in such programs as of July 1, 1995,
10 increased or decreased, as the case may be, by 45
11 percent of the difference between such enrollment
12 and the target enrollment established under para-
13 graph (1) and, not later than January 1, 2001, have
14 increased or decreased by 90 percent of such dif-
15 ference, and, by January 1, 2002, are deemed by the
16 National Council to be in compliance with the
17 target.

18 (4) LOSS OF COMPLIANCE.—The National
19 Council may, at any time, determine that a specialty
20 is not in compliance with the targets established
21 under paragraph (1) and initiate, with respect to
22 that specialty, the system of allocations described
23 under section 3013.

24 (f) STUDY.—Not later than January 1, 2005, the
25 Secretary shall arrange for the completion, by the Insti-

1 tute of Medicine or other similar entity, of an independent
2 study concerning the effect of medical workforce planning.
3 The results of such study together with recommendations
4 concerning the appropriateness of modifying or eliminat-
5 ing the planning program included in this Act shall be
6 compiled in a report and transmitted by the Secretary to
7 the President and the Congress.

8 (g) DEFINITIONS.—For purposes of this subtitle:

9 (1) The term “annual number of specialty posi-
10 tions”, with respect to a medical specialty, means
11 the number designated by the National Council
12 under subsection (a) for eligible programs for the
13 academic year involved.

14 (2) The term “designation period” means a 3-
15 year period under subsection (c)(1) for which des-
16 ignations under subsection (a) are made by the Na-
17 tional Council.

18 (3) The term “primary health care” means the
19 following medical specialties: Family medicine, gen-
20 eral internal medicine, general pediatrics, geriatric
21 medicine, obstetrics and gynecology, and medical
22 specialties (including psychiatry), if any, that have
23 been designated to be medical shortage specialties or
24 protected medical specialties by the Council on
25 Graduate Medical Education, or other similar physi-

1 cian advisory body authorized by Congress to pro-
 2 vide an ongoing assessment of physician workforce
 3 trends, and identify needs and be advisory to the
 4 Secretary, the Committee on Labor and Human Re-
 5 sources and the Committee on Finance of the Senate
 6 and the Committee on Energy and Commerce and
 7 the Committee on Ways and Means of the House of
 8 Representatives. Only those participants in programs
 9 with a significant primary care training emphasis
 10 will be considered to have completed an eligible pro-
 11 gram in primary care for the purposes of subsection
 12 (b)(1). Determination of meeting the definition of a
 13 “significant primary care training emphasis” will be
 14 made by the National Board.

15 (4) The term “specialty position” means a posi-
 16 tion as a training participant.

17 (5) The term “training participant” means an
 18 individual who is enrolled in an approved physician
 19 training program.

20 **SEC. 3013. ALLOCATIONS AMONG SPECIALTIES AND PRO-**
 21 **GRAMS.**

22 (a) IN GENERAL.—For each academic year, the Na-
 23 tional Council shall for each medical specialty make alloca-
 24 tions among eligible programs of the annual number of
 25 specialty positions that the Council has designated for

1 such year. The preceding sentence is subject to subsection
2 (b)(3).

3 (b) ALLOCATIONS REGARDING 3-YEAR PERIOD.—

4 (1) IN GENERAL.—For each medical specialty,
5 the National Council shall make the annual alloca-
6 tions under subsection (a) for periods of 3 academic
7 years.

8 (2) ADVANCE NOTICE TO PROGRAMS.—With re-
9 spect to the first academic year of an allocation pe-
10 riod established by the National Council, the Na-
11 tional Council shall, not later than July 1 of the pre-
12 ceding academic year, notify each eligible program of
13 the allocations made for the program for each of the
14 academic years of the period.

15 (3) INITIAL PERIOD.—The first allocation pe-
16 riod established by the National Council after the
17 date of the enactment of this Act shall be the aca-
18 demic years 2001–2002 through 2003–2004.

19 (c) CERTAIN CONSIDERATIONS.—

20 (1) GEOGRAPHIC AREAS; QUALITY OF PRO-
21 GRAMS.—In making allocations under subsection (a)
22 for eligible programs of the various geographic
23 areas, the National Council shall include among the
24 factors considered the historical distribution among

1 the areas of approved physician training programs,
2 and the quality of such programs.

3 (2) UNDERREPRESENTATION OF MINORITY
4 GROUPS AND WOMEN.—In making an allocation
5 under subsection (a) for an eligible program, the
6 National Council shall include among the factors
7 considered the following:

8 (A) The extent to which the population of
9 training participants in the program includes
10 training participants who are members of racial
11 or ethnic minority groups and women.

12 (B) With respect to a racial or ethnic
13 group or women represented among the train-
14 ing participants, the extent to which the group
15 is underrepresented in the field of medicine
16 generally and in the various medical specialties.

17 (3) UNDERSERVED RURAL AND INNER-CITY
18 COMMUNITIES.—In making allocations under sub-
19 section (a) for eligible programs, the National Coun-
20 cil shall consider the extent to which the population
21 of training participants in the program includes
22 training participants who have resided in rural or
23 inner-city communities and the proportion of past
24 participants in the program who are practicing in
25 rural or inner-city communities.

1 (4) RECOMMENDATIONS OF PRIVATE ORGANIZA-
 2 TIONS.—In making allocations under subsection (a)
 3 for eligible programs, the National Council shall con-
 4 sider the recommendations of organizations rep-
 5 resenting physicians in the medical specialties, the
 6 recommendations of organizations representing aca-
 7 demic medicine and the recommendations of organi-
 8 zations representing consumers of the services of
 9 such physicians.

10 (d) DEFINITIONS.—For purposes of this subtitle, the
 11 term “allocation period” means a 3-year period under sub-
 12 section (b)(1) for which allocations under subsection (a)
 13 are made by the National Council.

14 **Subpart C—Costs of Graduate Medical Education**

15 **CHAPTER 1—OPERATION OF APPROVED**
 16 **PHYSICIAN TRAINING PROGRAMS**

17 **SEC. 3031. FEDERAL FORMULA PAYMENTS TO QUALIFIED**
 18 **ENTITIES FOR THE COSTS OF THE OPER-**
 19 **ATION OF APPROVED PHYSICIAN TRAINING**
 20 **PROGRAMS.**

21 (a) IN GENERAL.—In the case of a qualified entity
 22 that in accordance with section 3032 submits to the Sec-
 23 retary an application for calendar year 1997 or any subse-
 24 quent calendar year, the Secretary shall make payments
 25 for such year to the qualified entity for the purpose speci-

1 fied in subsection (b). The Secretary shall make the pay-
2 ments in an amount determined in accordance with section
3 3033, and may administer the payments as a contract,
4 grant, or cooperative agreement.

5 (b) PAYMENTS FOR OPERATION OF APPROVED PHY-
6 SICIAN TRAINING PROGRAMS.—The purpose of payments
7 under subsection (a) is to assist a qualified applicant with
8 the costs of operation of an approved physician training
9 program. A funding agreement for such payments is that
10 the qualified applicant involved will expend the payments
11 only for such purpose.

12 (c) QUALIFIED APPLICANT; SUBPART DEFINITION.—

13 (1) IN GENERAL.—For purposes of this sub-
14 part, the term “qualified applicant”, with respect to
15 the calendar year involved, means an entity—

16 (A) that trains individuals in approved
17 physician training programs;

18 (B) that submits to the Secretary an appli-
19 cation for such year in accordance with section
20 3032; and

21 (C) if the entity has an approved physician
22 training program in primary health care, that
23 rotates individuals enrolled in the program to
24 health centers or other community programs in
25 underserved urban or rural areas.

1 (2) ENTITIES INCLUDED.—The term “qualified
2 applicant” may include a teaching hospital, medical
3 school, group practice, an entity representing two or
4 more parties engaged in a formal association, a com-
5 munity health center or another entity operating an
6 approved physician training program.

7 (d) TREATMENT OF PODIATRIC AND DENTAL RESI-
8 DENCY PROGRAMS.—For the purposes of chapters 1 and
9 3 of subpart C, an approved physician training program
10 includes training programs approved by the Commission
11 on Dental Accreditation or the Council of Podiatric Medi-
12 cal Education of the American Podiatric Medical Associa-
13 tion. This subsection shall not apply for purposes of sub-
14 part B.

15 **SEC. 3032. APPLICATION FOR PAYMENTS.**

16 (a) IN GENERAL.—

17 (1) IN GENERAL.—For purposes of section
18 3031(a), an application for payments under such
19 section for a calendar year is in accordance with this
20 section if—

21 (A) the eligible entity involved submits the
22 application not later than the date specified by
23 the Secretary;

1 (B) the application demonstrates that the
2 condition described in subsection (b) is met
3 with respect to the program;

4 (C) the application contains each funding
5 agreement described in this part and the appli-
6 cation provides such assurances of compliance
7 with the agreements as the Secretary may re-
8 quire; and

9 (D) the application is in such form, is
10 made in such manner, and contains such agree-
11 ments, assurances, and information as the Sec-
12 retary determines to be necessary to carry out
13 this part.

14 (2) CERTAIN ENTITIES.—If an applicant under
15 paragraph (1) is an entity representing two or more
16 parties—

17 (A) the application shall contain a written
18 agreement, signed by all participants, in which
19 all of the participants agree as to the manner
20 in which the payments will be allocated; and

21 (B) the applicant shall agree to submit ad-
22 ditional documentation, if requested by the Na-
23 tional Council, that demonstrates that the
24 funds are distributed in the manner agreed
25 upon by all participants.

1 (b) CERTAIN CONDITIONS.—An eligible entity meets
2 the condition described in this subsection for receiving
3 payments under section 3031 for a calendar year if—

4 (1) the entity agrees to use such funds only to
5 support an approved physician training program;

6 (2) with respect to—

7 (A) a specialty for which programs have
8 received allocations under section 3013, the en-
9 tity agrees that funds will only be used to sup-
10 port approved training programs for which the
11 number of specialists in training is consistent
12 with the allotment under section 3013; and

13 (B) a specialty for which a voluntary pro-
14 gram has received allocations under section
15 3012(e), the entity agrees that funds will only
16 be used to support approved training programs
17 for which the number of specialists in training
18 is consistent with the targets under section
19 3012(e); and

20 (3) the application of the entity contains a writ-
21 ten agreement, signed by all participants, in which
22 all participants agree to the manner in which the
23 payments will be allocated; and

24 (4) the entity agrees to submit additional docu-
25 mentation, if requested by the National Council, that

1 demonstrates that the funds will be distributed in a
2 manner agreed upon by all participants.

3 **SEC. 3033. AVAILABILITY OF FUNDS FOR PAYMENTS; AN-**
4 **NUAL AMOUNT OF PAYMENTS.**

5 (a) ANNUAL HEALTH PROFESSIONS WORKFORCE
6 ACCOUNT.—Subject to paragraph (2), the amount avail-
7 able for a calendar year for making payments under sec-
8 tions 3031 and 3061 (constituting an account to be known
9 as the annual health professions workforce account) is the
10 following, as applicable to the calendar year:

11 (1) In the case of calendar year 1997,
12 \$3,550,000,000.

13 (2) In the case of each of the calendar years
14 1998, 1999, and 2000, \$5,800,000,000.

15 (3) In the case of each subsequent calendar
16 year, the amount specified in paragraph (2) in-
17 creased by the product of such amount and the gen-
18 eral health care inflation factor for such year (as de-
19 fined in subsection (d)).

20 (b) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGI-
21 BLE ENTITIES.—

22 (1) IN GENERAL.—Payment amounts with re-
23 spect to any physician training program under this
24 section shall be equal to the product of the number
25 of full time equivalent training participants in the

1 program, and the per resident amount for the train-
2 ing program.

3 (2) PER RESIDENT AMOUNT.—The per resident
4 amount for a training program shall be equal to—

5 (A) with respect to—

6 (i) the first calendar years during
7 which the program is in operation, 90 per-
8 cent;

9 (ii) the second calendar years during
10 which the program is in operation, 80 per-
11 cent;

12 (iii) the third calendar years during
13 which the program is in operation, 70 per-
14 cent;

15 (iv) the fourth calendar years during
16 which the program is in operation, 60 per-
17 cent; and

18 (v) the fifth and subsequent calendar
19 years during which the program is in oper-
20 ation, 50 percent;

21 of the all payer hospital per resident cost; and

22 (B) with respect to—

23 (i) the first calendar years during
24 which the program is in operation, 10 per-
25 cent;

1 (ii) the second calendar years during
2 which the program is in operation, 20 per-
3 cent;

4 (iii) the third calendar years during
5 which the program is in operation, 30 per-
6 cent;

7 (iv) the fourth calendar years during
8 which the program is in operation, 40 per-
9 cent; and

10 (v) the fifth and subsequent calendar
11 years during which the program is in oper-
12 ation, 50 percent;

13 of the geographically adjusted national average
14 per resident amount.

15 (3) ADJUSTMENT FACTOR.—Payments under
16 this section shall be subject to an adjustment factor,
17 as determined by the Secretary, so that total pay-
18 ments in any year will not exceed the amounts speci-
19 fied in section 3033(a) and as provided in section
20 3033(c).

21 (4) ADDITIONAL PROVISIONS REGARDING NA-
22 TIONAL AVERAGE COST.—

23 (A) The Secretary shall in accordance with
24 paragraph (1)(B) determine, for academic year
25 1992–93, an amount equal to the national aver-

1 age described in such paragraph with respect to
2 training a participant in an approved physician
3 training program in the medical specialty in-
4 volved. The national average applicable under
5 such paragraph for a calendar year for such
6 programs is, subject to subparagraph (B), the
7 amount determined under the preceding sen-
8 tence increased by the amount necessary to off-
9 set the effects of inflation occurring since aca-
10 demic year 1992–93, as determined through use
11 of the consumer price index.

12 (B) The national average determined
13 under subparagraph (A) and applicable to a cal-
14 endar year shall, in the case of the eligible en-
15 tity involved, be adjusted by a factor to reflect
16 regional differences in the applicable wage and
17 wage-related costs.

18 (5) FUNDING LEVEL AND ALLOCATION METH-
19 OD.—Not later than January 1, 2000, the Secretary
20 shall complete a study to determine the effect of the
21 funding level and allocation method described in sub-
22 section (a) and paragraphs (1) and (2) of this sub-
23 section on the operation of training programs and
24 shall compile the findings and recommendations de-

1 rived from such study in a report to be submitted
2 to the President and the Congress.

3 (c) LIMITATION.—If, subject to subsection (a)(2), the
4 annual health professions workforce account available for
5 a calendar year is insufficient for providing each eligible
6 entity with the amount of payments determined under
7 subsection (b) for the entity for such year, the Secretary
8 shall make such pro rata reductions in the amounts so
9 determined as may be necessary to ensure that the total
10 of payments made under section 3031 for such year equals
11 the total of such account.

12 (d) DEFINITIONS.—For purposes of this subtitle:

13 (1) The term “annual health professions
14 workforce account” means the account established
15 pursuant to subsection (a)(1).

16 (2) The term “consumer price index” has the
17 meaning given such term in section 1702.

18 (3) The term “general health care inflation fac-
19 tor”, with respect to a year, has the meaning given
20 such term in section 5001(a)(3) for such year.

1 **CHAPTER 2—MEDICAL SCHOOL FUND**
2 **ACCOUNT**

3 **SEC. 3041. FEDERAL PAYMENTS TO THE MEDICAL SCHOOL**
4 **FUND.**

5 (a) IN GENERAL.—In the case of an eligible medical
6 school that in accordance with section 3042 submits to
7 the Secretary an application for academic year 1997, or
8 any subsequent academic year, the Secretary shall make
9 payments for such year to the school for the purpose speci-
10 fied in subsection (b). The Secretary shall make the pay-
11 ments in an amount determined in accordance with section
12 3043, and shall administer the payments as a grant.

13 (b) PAYMENTS FOR THE MEDICAL SCHOOL FUND.—
14 The purpose specified in this subsection is to assist an
15 eligible medical school with the direct costs of academic
16 programs, including the education of medical students (es-
17 pecially in ambulatory and preventive medicine), graduate
18 students in biomedical sciences, and otherwise unfunded
19 faculty research. A funding agreement for such payments
20 is that the medical school involved will expend the pay-
21 ments only for direct expenses determined as allowable by
22 the Secretary.

23 (c) ELIGIBLE MEDICAL SCHOOL; SUBPART DEFINI-
24 TION.—For purposes of this subpart, the term “eligible
25 medical school” with respect to the academic year in-

1 volved, means an approved medical school that submits to
 2 the Secretary an application for such year in accordance
 3 with section 3043.

4 **SEC. 3042. APPLICATION FOR PAYMENTS.**

5 For purposes of section 3041(a), an application for
 6 payments under such section for an academic year is in
 7 accordance with this section if—

8 (1) the dean (or appropriate presiding official)
 9 of the eligible medical school submits the application
 10 not later than the date specified by the Secretary;

11 (2) the application contains each funding agree-
 12 ment described in this subpart and provides such as-
 13 surances of compliance with the agreements as the
 14 Secretary may require; and

15 (3) the application is in such form, is made in
 16 such manner, and contains such agreements, assur-
 17 ances, and information as the Secretary determines
 18 to be necessary to carry out this part.

19 **SEC. 3043. AVAILABILITY OF FUNDS FOR PAYMENTS; AN-**
 20 **NUAL AMOUNT OF PAYMENTS.**

21 (a) ANNUAL MEDICAL SCHOOL FUND ACCOUNT.—
 22 Subject to section 3043, the amount available for an aca-
 23 demic year for making payments under section 3041 (con-
 24 stituting an account to be known as the annual medical

1 school fund account) shall be the following, as applicable
2 to the academic year:

3 (1) In the case of academic year 1997,
4 \$200,000,000.

5 (2) In the case of academic year 1998,
6 \$300,000,000.

7 (3) In the case of academic year 1999,
8 \$400,000,000.

9 (4) In the case of academic year 2000,
10 \$500,000,000.

11 (5) In the case of academic year 2001,
12 \$600,000,000.

13 (6) In the case of each subsequent calendar
14 year, the amount specified in paragraph (5) in-
15 creased by the product of such amount and the gen-
16 eral health care inflation factor (as defined in sub-
17 section (d)).

18 (b) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGI-
19 BLE PROGRAMS.—Subject to the annual medical school
20 fund account available for an academic year, the amount
21 of payment required under section 3041 to be made to
22 an eligible medical school for the academic year is an
23 amount equal to the sum of—

24 (1) the product of $\frac{3}{4}$ of the fund account avail-
25 able and the proportion of full-time equivalent stu-

1 dents at the eligible medical school in academic year
2 1993–1994 compared to all full-time equivalent stu-
3 dents enrolled in eligible medical schools nationwide
4 in academic year 1993–1994; and

5 (2) the product of $\frac{1}{4}$ of the fund account avail-
6 able and the proportion of research conducted by the
7 faculty at the eligible medical school compared to all
8 research conducted by the faculty at all eligible med-
9 ical schools nationwide.

10 The Secretary shall establish a method for measuring fac-
11 ulty research contributions.

12 (c) STUDIES.—

13 (1) FUNDING LEVEL AND ALLOCATION METH-
14 OD.—Not later than January 1, 1999, the Secretary
15 shall arrange for an independent study and report to
16 be completed, by the Institute of Medicine or other
17 similar entity, concerning the amount of and alloca-
18 tion method for medical school funding. Such report
19 shall be submitted to the President and the Con-
20 gress and shall include findings and recommendation
21 as to the appropriateness of modifying funding levels
22 or allocation.

23 (2) Not later than January 1, 2001, the Sec-
24 retary shall arrange for an independent study and
25 report to be completed, by the Institute of Medicine

1 or other similar entity, concerning the impact of
 2 health reform on undergraduate and graduate medi-
 3 cal education. Such report shall be submitted to the
 4 President and the Congress and shall include appro-
 5 priate findings and recommendations.

6 (d) DEFINITIONS.—As used in this subtitle:

7 (1) The term “annual medical school fund ac-
 8 count” means the account established under sub-
 9 section (a).

10 (2) The term “general health care inflation fac-
 11 tor” with respect to a year, has the meaning given
 12 such term in section 5001(a)(3) for such year.

13 **CHAPTER 3—ACADEMIC HEALTH** 14 **CENTERS**

15 **SEC. 3051. FEDERAL FORMULA PAYMENTS TO ACADEMIC** 16 **HEALTH CENTERS.**

17 (a) IN GENERAL.—In the case of a qualified aca-
 18 demic health center or qualified teaching hospital that in
 19 accordance with section 3052 submits to the Secretary a
 20 written request for calendar year 1997 or any subsequent
 21 calendar year, the Secretary shall make payments for such
 22 year to the center or hospital for the purpose specified
 23 in subsection (b). The Secretary shall make the payments
 24 in an amount determined in accordance with section 3053,

1 and may administer the payments as a contract, grant,
2 or cooperative agreement.

3 (b) PAYMENTS FOR COSTS ATTRIBUTABLE TO Aca-
4 DEMIC NATURE OF INSTITUTIONS.—The purpose of pay-
5 ments under subsection (a) is to assist eligible institutions
6 with costs that are not routinely incurred by other entities
7 in providing health services, but are incurred by such insti-
8 tutions in providing health services by virtue of the aca-
9 demic nature of such institutions. Such costs include—

10 (1) with respect to productivity in the provision
11 of health services, costs resulting from the reduced
12 rate of productivity of faculty due to teaching re-
13 sponsibilities;

14 (2) the uncompensated costs of clinical re-
15 search; and

16 (3) exceptional costs associated with the treat-
17 ment of health conditions with respect to which an
18 eligible institution has specialized expertise (includ-
19 ing treatment of rare diseases, treatment of unusu-
20 ally severe conditions, and providing other special-
21 ized health care).

22 (c) DEFINITIONS.—

23 (1) ACADEMIC HEALTH CENTER.—For purposes
24 of this subtitle, the term “academic health center”
25 means an entity that operates a teaching hospital

1 that carries out an approved physician training pro-
2 gram.

3 (2) TEACHING HOSPITAL.—For purposes of this
4 subtitle, the term “teaching hospital” means a hos-
5 pital that operates an approved physician training
6 program (as defined in section 3011(b) or section
7 3031(d)).

8 (3) QUALIFIED CENTER OR HOSPITAL.—For
9 purposes of this subtitle:

10 (A) The term “qualified academic health
11 center” means an academic health center that
12 operates a teaching hospital.

13 (B) The term “qualified teaching hospital”
14 means any teaching hospital other than a teach-
15 ing hospital that is operated by an academic
16 health center.

17 (4) ELIGIBLE INSTITUTION.—For purposes of
18 this subtitle, the term “eligible institution”, with re-
19 spect to a calendar year, means a qualified academic
20 health center, or a qualified teaching hospital, that
21 submits to the Secretary a written request in accord-
22 ance with section 3052.

23 **SEC. 3052. REQUEST FOR PAYMENTS.**

24 (a) IN GENERAL.—For purposes of section 3051, a
25 written request for payments under such section is in ac-

1 cordance with this section if the qualified academic health
2 center or qualified teaching hospital involved submits the
3 request not later than the date specified by the Secretary;
4 the request is accompanied by each funding agreement de-
5 scribed in this part; and the request is in such form, is
6 made in such manner, and contains such agreements, as-
7 surances, and information as the Secretary determines to
8 be necessary to carry out this part.

9 (b) CONTINUED STATUS AS ACADEMIC HEALTH
10 CENTER.—A funding agreement for payments under sec-
11 tion 3051 is that the qualified academic health center or
12 qualified teaching hospital involved will maintain status as
13 such a center or hospital, respectively. For purposes of
14 this subtitle, the term “funding agreement”, with respect
15 to payments under section 3051 to such a center or hos-
16 pital, means that the Secretary may make the payments
17 only if the center or hospital makes the agreement in-
18 volved.

19 **SEC. 3053. AVAILABILITY OF FUNDS FOR PAYMENTS; AN-**
20 **NUAL AMOUNT OF PAYMENTS.**

21 (a) ANNUAL ACADEMIC HEALTH CENTER AC-
22 COUNT.—The amount available for a calendar year for
23 making payments under section 3051 (constituting an ac-
24 count to be known as the annual academic health center

1 account) is the following, as applicable to the calendar
2 year:

3 (1) In the case of calendar year 1997,
4 \$7,250,000,000.

5 (2) In the case of calendar year 1998,
6 \$8,220,000,000.

7 (3) In the case of calendar year 1999,
8 \$9,400,000,000.

9 (4) In the case of calendar year 2000,
10 \$10,640,000,000.

11 (5) In the case of each subsequent calendar
12 year, the amount specified in paragraph (4) in-
13 creased by the product of such amount and the gen-
14 eral health care inflation factor (as defined in sub-
15 section (d)).

16 (b) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGI-
17 BLE INSTITUTIONS.—

18 (1) FORMULA.—The amount of payments re-
19 quired in section 3051 to be made to an eligible in-
20 stitution for a calendar year is an amount equal to
21 the product of—

22 (A) the annual academic health center ac-
23 count available for the calendar year; and

24 (B) the percentage constituted by the ratio
25 of—

1 (i) the product of—

2 (I) the sum, for all discharges of
3 individuals, of the amounts otherwise
4 paid on behalf of such individuals;
5 and

6 (II) an adjustment factor equal
7 to 1.200 multiplied by $((1+r)^n - 1)$, where “r” equals
8 the ratio of the hospital’s full-time
9 equivalent interns and residents to
10 beds and “n” equals .405; and

11 (ii) the sum of the respective amounts
12 determined under clause (i) for eligible in-
13 stitutions.
14

15 (2) ADJUSTMENT FACTOR.—Payments under
16 this section shall be subject to an adjustment factor,
17 as determined by the Secretary, so that total pay-
18 ments in any year will not exceed the amounts speci-
19 fied in section 3053(a).

20 (c) REPORT REGARDING MODIFICATIONS IN FOR-
21 MULA.—Not later than July 1, 2001, the Secretary shall
22 submit to the Congress a report containing any rec-
23 ommendations of the Secretary for the modification of the
24 program of formula payments described in this chapter.
25 In preparing such report the Secretary shall consider—

1 (1) the costs described in subsection (b) in-
2 curred by academic health centers;

3 (2) the adequacy of the formula payments es-
4 tablished in this chapter to cover such costs, taking
5 into account any additional revenues to cover such
6 costs paid by other payers, including private health
7 plans;

8 (3) the importance to the maintenance of a
9 quality national health care system of academic
10 health centers in providing for the training of health
11 professionals, in conducting clinical research, and in
12 providing innovative, technically advanced care; and

13 (4) the overall impact of the reformed health
14 care system on the ability of academic health centers
15 to perform such functions.

16 (d) DEFINITION.—For purposes of this subtitle:

17 (1) The term “annual academic health center
18 account” means the account established pursuant to
19 subsection (a).

20 (2) The term “general health care inflation fac-
21 tor”, with respect to a year, has the meaning given
22 such term in section 5001(a)(3) for such year.

1 **Subpart D—Transitional Provisions**

2 **SEC. 3061. TRANSITIONAL PAYMENTS TO INSTITUTIONS.**

3 (a) PAYMENTS REGARDING EFFECTS OF SUBPART B
4 ALLOCATIONS.—For each of the four calendar years speci-
5 fied in subsection (b)(2), in the case of an eligible entity
6 that submits to the Secretary an application for such year
7 in accordance with subsection (d), the Secretary shall
8 make payments for the year to the entity for the purpose
9 specified in subsection (c). The Secretary shall make the
10 payments in an amount determined in accordance with
11 subsection (e), and may administer the payments as a con-
12 tract, grant, or cooperative agreement.

13 (b) ELIGIBLE ENTITIES LOSING SPECIALTY POSI-
14 TIONS; RELEVANT YEARS REGARDING PAYMENTS.—

15 (1) ELIGIBLE ENTITIES LOSING SPECIALTY PO-
16 SITIONS.—The Secretary may make payments under
17 subsection (a) to an eligible entity only if, with re-
18 spect to the calendar year involved, the entity meets
19 the following conditions:

20 (A) The entity operates or operated in the
21 year preceding the initiation of transitional pay-
22 ments one or more programs that—

23 (i) are or were at the time they termi-
24 nated approved physician training pro-
25 grams; and

1 (ii) are or were at the time they ter-
2 minated receiving payments under section
3 3031 for such year.

4 (B) The aggregate number of speciality po-
5 sitions in such programs (in the medical speci-
6 alities with respect to which such payments are
7 made) is below the aggregate number of such
8 positions at the entity for academic year 1993–
9 94 as a result of allocations under subpart B,
10 or as a result of voluntary changes under sec-
11 tion 3012(e) prior to January 1, 2001.

12 (2) RELEVANT YEARS.—The Secretary may
13 make payments under subsection (a) to an eligible
14 entity only for the first four calendar years after the
15 initial calendar year for which the entity meets the
16 conditions described in paragraph (1).

17 (3) ELIGIBLE ENTITY.—For purposes of this
18 section, the term “eligible entity” means an entity
19 that submits to the Secretary an application in ac-
20 cordance with subsection (d).

21 (c) PURPOSE OF PAYMENTS.—The purpose of pay-
22 ments under subsection (a) is to assist an eligible entity
23 with the costs of operation. A funding agreement for such
24 payments is that the entity involved will expend the pay-
25 ments only for such purpose.

1 (d) APPLICATION FOR PAYMENTS.—For purposes of
2 subsection (a), an application for payments under such
3 subsection is in accordance with this subsection if—

4 (1) the eligible entity involved submits the ap-
5 plication not later than the date specified by the
6 Secretary;

7 (2) the application demonstrates that the entity
8 meets the conditions described in subsection (b)(1)
9 and that the entity has cooperated with the approved
10 physician training programs of the entity in meeting
11 the condition described in section 3032(b);

12 (3) the application contains each funding agree-
13 ment described in this subpart and the application
14 provides such assurances of compliance with the
15 agreements as the Secretary may require; and

16 (4) the application is in such form, is made in
17 such manner, and contains such agreements, assur-
18 ances, and information as the Secretary determines
19 to be necessary to carry out this subpart.

20 (e) AMOUNT OF PAYMENTS.—

21 (1) IN GENERAL.—Subject to the annual health
22 professions workforce account available for the cal-
23 endar year involved, the amount of payments re-
24 quired in subsection (a) to be made to an eligible en-
25 tity for such year is the product of the amount de-

1 terminated under paragraph (2) and the applicable
2 percentage specified in paragraph (3).

3 (2) NUMBER OF SPECIALTY POSITIONS LOST.—

4 For purposes of paragraph (1), the amount deter-
5 mined under this paragraph for an eligible entity for
6 the calendar year involved is the product of—

7 (A) an amount equal to the aggregate
8 number of full-time equivalent specialty posi-
9 tions lost; and

10 (B) the amount that would be received
11 under section 3033 for each speciality position
12 lost.

13 (3) APPLICABLE PERCENTAGE.—For purposes
14 of paragraph (1), the applicable percentage for a cal-
15 endar year is the following, as applicable to such
16 year:

17 (A) For the first calendar year after cal-
18 endar year 1997 for which the eligible entity in-
19 volved meets the conditions described in sub-
20 section (b)(1), 100 percent.

21 (B) For the second such year, 75 percent.

22 (C) For the third such year, 50 percent.

23 (D) For the fourth such year, 25 percent.

24 (4) DETERMINATION OF SPECIALTY POSITIONS
25 LOST.—

1 (A) For purposes of this subsection, the
2 aggregate number of specialty positions lost,
3 with respect to a calendar year, is the difference
4 between—

5 (i) the aggregate number of specialty
6 positions described in subparagraph (B)
7 that are estimated for the eligible entity in-
8 volved for the academic year beginning in
9 such calendar year; and

10 (ii) the aggregate number of such spe-
11 cialty positions at the entity for academic
12 year 1993–94.

13 (B) For purposes of subparagraph (A), the
14 specialty positions described in this subpara-
15 graph are specialty positions in the medical spe-
16 cialties with respect to which payments under
17 section 3031 are made to the approved physi-
18 cian training programs of the eligible entities
19 involved.

20 (5) ADDITIONAL PROVISION REGARDING NA-
21 TIONAL AVERAGE SALARY.—

22 (A) The Secretary shall determine, for aca-
23 demic year 1992–93, an amount equal to the
24 national average described in paragraph (2)(B).
25 The national average applicable under such

1 paragraph for a calendar year is, subject to
2 subparagraph (B), the amount determined
3 under the preceding sentence increased by an
4 amount necessary to offset the effects of infla-
5 tion occurring since academic year 1992–93, as
6 determined through use of the consumer price
7 index.

8 (B) The national average determined
9 under subparagraph (A) and applicable to a cal-
10 endar year shall, in the case of the eligible en-
11 tity involved, be adjusted by a factor to reflect
12 regional differences in the applicable wage and
13 wage-related costs.

14 **PART 2—INSTITUTIONAL COSTS OF GRADUATE**

15 **NURSING EDUCATION; WORKFORCE PRIORITIES**

16 **SEC. 3071. AUTHORIZED GRADUATE NURSE TRAINING POSI-**
17 **TIONS; INSTITUTIONAL COSTS.**

18 (a) PROGRAM REGARDING GRADUATE NURSE TRAIN-
19 ING PROGRAMS.—The Secretary shall, in accordance with
20 this part, carry out a program with respect to graduate
21 nurse training programs that is equivalent to the program
22 carried out under part 1 with respect to approved physi-
23 cian training programs.

24 (b) DEFINITIONS.—For purposes of this part:

1 (1) The term “graduate nurse training pro-
2 grams” means programs for advanced nurse edu-
3 cation, programs for education as nurse practition-
4 ers, programs for education as nurse midwives, pro-
5 grams for education as nurse anesthetists, and such
6 other programs for training in clinical nurse special-
7 ties as are determined by the Secretary to require
8 advanced education.

9 (2) The term “graduate nurse training posi-
10 tion” means a position as an individual who is en-
11 rolled in a graduate nurse training program.

12 (3) The term “programs for advanced nurse
13 education” means programs meeting the conditions
14 to be programs for which awards of grants and con-
15 tracts may be made under section 821 of the Public
16 Health Service Act.

17 (4) The term “programs for education as nurse
18 practitioners” means programs meeting the condi-
19 tions to be programs for which awards of grants and
20 contracts may be made under section 822 of the
21 Public Health Service Act for education as a nurse
22 practitioners.

23 (5) The term “programs for education as nurse
24 midwives” means programs meeting the conditions
25 to be programs for which awards of grants and con-

1 tracts may be made under section 822 of the Public
2 Health Service Act for education as nurse midwives.

3 (6) The term “programs for education as nurse
4 anesthetists” means programs meeting the condi-
5 tions to be programs for which awards of grants
6 may be made under section 831 of the Public Health
7 Service Act for education as nurse anesthetists.

8 **SEC. 3072. APPLICABILITY OF PART 1 PROVISIONS.**

9 (a) IN GENERAL.—The provisions of part 1 apply to
10 the program carried out under section 3071 to the same
11 extent and in the same manner as such provisions apply
12 to the program carried out under part 1, subject to the
13 subsequent provisions of this section. Section 3061 does
14 not apply for purposes of the preceding sentence.

15 (b) NATIONAL COUNCIL.—With respect to section
16 3001 as applied to this part, the council shall be known
17 as the National Council on Graduate Nurse Education (in
18 this part referred to as the “National Council”). The pro-
19 visions of section 851 of the Public Health Service Act
20 regarding the composition of the council under such sec-
21 tion apply to the composition of the National Council to
22 the same extent and in the same manner as such provi-
23 sions apply to the council under such section 851.

24 (c) ALLOCATION OF GRADUATE NURSE TRAINING
25 POSITIONS; FORMULA PAYMENTS FOR OPERATING

1 COSTS.—With respect to subparts B and C of part 1 as
2 applied to this part—

3 (1) the funding agreement described in section
4 3011 is to be made by graduate nurse training pro-
5 grams;

6 (2) the applicable accrediting bodies described
7 in section 3011 for graduate nurse training pro-
8 grams are the National League of Nursing and oth-
9 ers determined to be appropriate by the Secretary;

10 (3) designations under section 3012 and alloca-
11 tions under section 3013 apply to graduate nurse
12 training positions; and

13 (4) payments under section 3031 are to be
14 made to graduate nurse training programs, subject
15 to the requirements for such payments.

16 **SEC. 3073. FUNDING.**

17 (a) IN GENERAL.—With respect to section 3033 as
18 applied to this part, the provisions of this section apply.

19 (b) ANNUAL GRADUATE NURSE TRAINING AC-
20 COUNT.—The amount available for each of the calendar
21 years 1997 through 2000 for making payments pursuant
22 to section 3072(c)(4) to graduate nurse training programs
23 (constituting an account to be known as the annual grad-
24 uate nurse training account) is \$200,000,000.

1 **Subpart B—Transitional Provisions for Workforce**
2 **Stability**

3 **SEC. 3081. APPLICATION.**

4 (a) LIMITATION TO TRANSITION PERIOD.—The pro-
5 visions of this subpart are intended to minimize, to the
6 extent possible, disruptions in established employment re-
7 lationships during the period of transition to a restruc-
8 tured health care delivery system, and shall terminate De-
9 cember 31, 2000.

10 (b) HEALTH CARE ENTITIES COVERED BY SUB-
11 PART.—The provisions of this subpart, including ref-
12 erences to displacing employers, hiring employers, succes-
13 sors and contractors, apply only to health care entities
14 that employ more than 25 individuals.

15 **SEC. 3082. DEFINITIONS.**

16 (a) HEALTH CARE ENTITY.—As used in this sub-
17 part, the term “health care entity” includes individuals,
18 sole proprietorships, partnerships, associations, business
19 trusts, corporations, governmental institutions, and public
20 agencies (including state governments and political sub-
21 divisions thereof) that—

22 (1) provide health care services under title I
23 (including nonmandatory health care services under
24 title I) or under the amendments made or programs
25 referred to in titles IV and VIII; or

1 (2) provide necessary related services, including
2 administrative, food service, janitorial or mainte-
3 nance services, to an entity that provides health care
4 services (as described in subparagraph (1));

5 except that an entity that solely manufactures or provides
6 goods or equipment to a health care entity shall not be
7 considered a health care entity.

8 (b) AFFILIATED ENTERPRISE.—As used in this sub-
9 part, the term “affiliated enterprise” means a health care
10 entity that, together with the displacing employer, is con-
11 sidered a single employer as defined under 414 of the In-
12 ternal Revenue Code of 1986.

13 (c) PREFERENCE ELIGIBLE EMPLOYEE.—As used in
14 this subpart, the term “preference eligible employee”
15 means an employee who—

16 (1) has been employed for in excess of 1 year
17 by a health care entity; and

18 (2) has been displaced by or has received notice
19 of an impending displacement by such entity.

20 (d) DISPLACEMENT.—As used in this subpart, the
21 term “displacement” includes a layoff, termination, sig-
22 nificant cutback in paid work hours, or other loss of em-
23 ployment, except that a discharge for just cause shall not
24 constitute a displacement within the meaning of this para-
25 graph.

1 **SEC. 3083. OBLIGATIONS OF DISPLACING EMPLOYER AND**
2 **AFFILIATED ENTERPRISES IN EVENT OF DIS-**
3 **PLACEMENT.**

4 (a) NOTICE.—A health care entity which displaces a
5 preference eligible employee shall provide such employee
6 with—

7 (1) written notice, no later than the date of dis-
8 placement, of employment rights under this subpart,
9 including employment rights with respect to affili-
10 ated enterprises of the displacing employer; and

11 (2) notice of any existing or subsequent vacan-
12 cies with the displacing employer or an affiliated en-
13 terprise, which notice may be given by posting of
14 such vacancies wherever notices to applicants for
15 employment are customarily posted, by listing such
16 vacancies with the local employment services agency,
17 or in such other manner as the Secretary of Labor,
18 by regulation, may hereafter specify.

19 Any such vacancy shall remain open for applications by
20 preference eligible employees for not less than 14 calendar
21 days from the date on which the initial notice is provided.

22 (b) HIRING PREFERENCE.—

23 (1) IN GENERAL.—A qualified preference eligi-
24 ble employee who applies during the notice period
25 described in subsection (a)(2) for a vacant position
26 with the displacing employer or an affiliated enter-

1 prise, which position is in the employee's occupa-
2 tional specialty and is located in the same State or
3 Standard Metropolitan Statistical Area in which the
4 employee was employed prior to the displacement,
5 shall be given the right to accept or decline the posi-
6 tion before the employer may offer the position to a
7 nonpreference eligible employee.

8 (2) MULTIPLE APPLICATIONS.—When consider-
9 ing applications from more than one qualified pref-
10 erence eligible employee, the hiring health care en-
11 tity shall have discretion as to which of such employ-
12 ees will be offered the position.

13 (3) EMPLOYMENT QUALIFICATIONS.—Nothing
14 in this subsection shall be construed to prohibit the
15 hiring health care entity from establishing reason-
16 able employment qualifications for a vacancy to
17 which this subpart applies, except that employees
18 who performed essentially the same work prior to
19 their displacement shall be deemed presumptively
20 qualified for comparable positions.

21 (c) TERMINATION OF PREFERENCE ELIGIBILITY.—
22 A displaced employee's preference eligibility shall termi-
23 nate—

1 (1) at such time as the displaced employee ob-
2 tains substantially equivalent employment with the
3 displacing employer; or

4 (2) if the employee does not obtain such em-
5 ployment—

6 (A) with respect to health care entities
7 other than the displacing employer, 2 years
8 after the date of the displacement; or

9 (B) with respect to the displacing em-
10 ployer, upon the termination of this subpart
11 pursuant to section 3081(a).

12 **SEC. 3084. EMPLOYMENT WITH SUCCESSORS.**

13 A health care entity that succeeds another health care
14 entity through merger, consolidation, acquisition, contract,
15 or other similar manner shall provide employees of the
16 previous health care entity who would otherwise be dis-
17 placed the right to continued employment in the job posi-
18 tions held by such employees prior thereto, unless the em-
19 ployer can establish that such positions no longer exist.

20 **SEC. 3085. COLLECTIVE BARGAINING OBLIGATIONS DUR-**
21 **ING TRANSITION PERIOD.**

22 (a) CONTINUATION OF PREVIOUSLY RECOGNIZED
23 BARGAINING REPRESENTATIVES AND AGREEMENTS.—If
24 a majority of the employees in an appropriate bargaining
25 unit consists of employees who were previously covered by

1 a bargaining agreement or represented by an exclusive
2 representative with respect to terms and conditions of em-
3 ployment, and there has not been a substantial change in
4 the operations performed by the employees in that unit,
5 the employer shall recognize such representative as the ex-
6 clusive representative for the unit and shall assume the
7 bargaining agreement, except that where application of
8 this subsection would result in the recognition of more
9 than one bargaining representative for a single unit, the
10 question concerning which representative shall be recog-
11 nized as the exclusive representative for the unit shall be
12 resolved in accordance with applicable Federal or State
13 law.

14 (b) JOINT EMPLOYER STATUS.—If employees of a
15 contractor are assigned on a regular basis to perform work
16 on the premises of a contracting entity and the tasks per-
17 formed by these employees are functionally integrated with
18 the operations of the contracting entity on whose premises
19 such employees work, both the contractor and the con-
20 tracting entity shall be considered joint employers of the
21 employees with respect to work performed on those prem-
22 ises for purposes of determining compliance with labor re-
23 lations laws. Employees of such joint employers may not
24 be excluded from a bargaining unit within either entity
25 on the basis of such joint employer status.

1 **SEC. 3086. GENERAL PROVISIONS.**

2 (a) REGULATIONS.—Not later than 120 days after
3 the date of enactment of this Act, the Secretary shall pro-
4 mulgate regulations to implement the requirements of sec-
5 tion 3083.

6 (b) OTHER LAWS.—The standards and requirements
7 of this subpart shall not preempt or excuse noncompliance
8 with any other applicable Federal or State law, regulation
9 or municipal ordinance that establishes additional notice
10 and preference standards or requirements concerning em-
11 ployee dislocation, employee representation, or collective
12 bargaining.

13 (c) RULES OF CONSTRUCTION.—Nothing in this sub-
14 part shall be construed—

15 (1) to excuse or otherwise limit the obligation
16 of an employer to comply with any collective bar-
17 gaining agreement or any employment benefit plan
18 that provides rights to employees in addition to
19 those provided under this subpart; or

20 (2) to require an employer to recognize or bar-
21 gain with a labor organization in violation of State
22 law.

23 (d) ENFORCEMENT.—Unless otherwise specifically
24 provided in this subpart, the enforcement provisions of
25 section 107 of the Family and Medical Leave Act of 1993
26 (29 U.S.C. 2617) shall apply with respect to the enforce-

1 ment of the individual rights, including notice require-
 2 ments, provided under section 3083. The collective bar-
 3 gaining and contractual rights provided under sections
 4 3084 and 3085 shall be enforced through administrative
 5 and judicial procedures otherwise provided under Federal
 6 or State law with respect to such rights.

7 **Subtitle B—Health Research** 8 **Initiatives**

9 **PART 1—PROGRAMS FOR CERTAIN AGENCIES**

10 **SEC. 3101. BIOMEDICAL AND BEHAVIORAL RESEARCH.**

11 (a) AVAILABILITY OF FUNDS.—

12 (1) IN GENERAL.—With respect to each cal-
 13 endar year, the Secretary shall pay, from funds in
 14 the Treasury not otherwise appropriated, for activi-
 15 ties under this section in an amount equal to 0.25
 16 percent in 1997, 0.50 percent in 1998, 0.75 percent
 17 in 1999, and 1.0 percent in 2000 and subsequent
 18 years, of all private premiums required to be paid
 19 under this Act.

20 (2) For purposes of this subsection, the term
 21 “private health premiums” means all premium relat-
 22 ed payments made by employers, individuals, and
 23 families for coverage under this Act.

24 (b) PURPOSES FOR EXPENDITURES.—Part A of title
 25 IV of the Public Health Service Act (42 U.S.C. 281 et

1 seq.) is amended by adding at the end thereof the follow-
2 ing new section:

3 **“SEC. 404F. EXPENDITURES FOR HEALTH RESEARCH.**

4 “(a) IN GENERAL.—From amounts made available
5 under section 3101 of the Affordable Health Care for All
6 Americans Act, the Secretary shall distribute—

7 “(1) 2 percent of such amounts during any fis-
8 cal year to the Office of the Director of the National
9 Institutes of Health to be allocated at the Director’s
10 discretion for the following activities:

11 “(A) for carrying out the responsibilities of
12 the Office of the Director, in including the Of-
13 fice of Research on Women’s Health and the
14 Office of Research on Minority Health, the Of-
15 fice of Alternative Medicine and the Office of
16 Rare Diseases Research; and

17 “(B) for construction and acquisition of
18 equipment for or facilities of or used by the Na-
19 tional Institutes of Health;

20 “(2) 2 percent of such amounts for transfer to
21 the National Center for Research Resources to carry
22 out section 1502 of the National Institutes of
23 Health Revitalization Act of 1993 concerning Bio-
24 medical and Behavioral Research Facilities;

1 “(3) 1 percent of such amounts during any fis-
 2 cal year for carrying out section 301 and part D of
 3 title IV with respect to health information commu-
 4 nications; and

5 “(4) the remainder of such amounts during any
 6 fiscal year to member institutes of the National In-
 7 stitutes of Health and Centers in the same propor-
 8 tion to the total amount received under this section,
 9 as the amount of annual appropriations under ap-
 10 propriations Acts for each member institute and
 11 Centers for the fiscal year bears to the total amount
 12 of appropriations under appropriations Acts for all
 13 member institutes and Centers of the National Insti-
 14 tutes of Health for the fiscal year.

15 “(b) PLANS OF ALLOCATION.—The amounts trans-
 16 ferred under subsection (a) shall be allocated by the Direc-
 17 tor of NIH or the various directors of the institutes and
 18 centers, as the case may be, pursuant to allocation plans
 19 developed by the various advisory councils to such direc-
 20 tors, after consultation with such directors.”.

21 **SEC. 3102. HEALTH SERVICES RESEARCH.**

22 Section 902 of the Public Health Service Act (42
 23 U.S.C. 299a), as amended by section 2(b) of Public Law
 24 102–410 (106 Stat. 2094), is amended by adding at the
 25 end the following subsection:

1 “(f) RESEARCH ON HEALTH CARE REFORM.—

2 “(1) IN GENERAL.—In carrying out section
3 901(b), the Administrator shall conduct and support
4 research on the reform of the health care system of
5 the United States, as directed by the Secretary.

6 “(2) PRIORITIES.—In carrying out paragraph
7 (1), the Administrator shall give priority to the fol-
8 lowing:

9 “(A) Conducting and supporting research
10 on the appropriateness and effectiveness of al-
11 ternative clinical strategies (including commu-
12 nity-based programs and preventive services),
13 the quality and outcomes of care, and adminis-
14 trative simplification.

15 “(B) Conducting and supporting research
16 on the appropriateness and effectiveness of al-
17 ternative community-based and clinical strate-
18 gies including integrating preventive services
19 into primary care, the effectiveness of preven-
20 tive counseling and health education, and the
21 efficacy and cost-effectiveness of clinical preven-
22 tive services.

23 “(C) Conducting and supporting research
24 on consumer choice and information resources;
25 the effects of health care reform on health de-

livery systems; workplace injury and illness prevention; intentional and unintentional injury prevention; methods for risk adjustment; factors influencing access to health care for vulnerable populations, including children, persons with low-income, persons with disabilities, or individuals with chronic or complex health conditions, and primary care.

“(D) The development of clinical practice guidelines consistent with section 913, the dissemination of such guidelines consistent with section 903, and the assessment of the effectiveness of such guidelines.”.

PART 2—FUNDING FOR PROGRAM

SEC. 3111. AUTHORIZATIONS OF APPROPRIATIONS.

(a) HEALTH SERVICES RESEARCH.—For the purpose of carrying out activities pursuant to the amendments made by section 3102, there are authorized to be appropriated \$150,000,000 for fiscal year 1996, \$400,000,000 for fiscal year 1997, \$500,000,000 for fiscal year 1998, and \$600,000,000 for each of the fiscal years 1999 through 2001.

(b) RELATION TO OTHER FUNDS.—The authorization of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that

1 are available for the purposes described in such sub-
2 section.

3 (c) TRIGGER AND RELEASE OF MONIES.—No ex-
4 penditure shall be made pursuant to section 3101(c) dur-
5 ing any fiscal year in which the annual amount appro-
6 priated for the National Institutes of Health is less than
7 the amount so appropriated for the prior fiscal year. With
8 respect to amounts available for expenditure pursuant to
9 section 3101(c) which, as a result of the application of
10 this subsection remain unexpended, such amounts shall be
11 obligated by the Secretary of Health and Human Services
12 under the public health initiative under subtitle F.

13 **Subtitle C—Health Services for**
14 **Medically Underserved Popu-**
15 **lations**

16 **PART 1—INITIATIVES FOR ACCESS TO HEALTH**
17 **CARE**

18 **Subpart A—Authorization of Appropriations**

19 **SEC. 3311. AUTHORIZATIONS OF APPROPRIATIONS.**

20 (a) IMPROVING ACCESS TO HEALTH SERVICES.—

21 (1) SUBPART B.—

22 (A) Except as provided in subparagraph

23 (B), for the purpose of carrying out subpart B,

24 there are authorized to be appropriated

25 \$52,500,000 for fiscal year 1996, \$122,500,000

1 for fiscal year 1997, \$192,500,000 for fiscal
2 year 1998, \$157,500,000 for fiscal year 1999,
3 \$122,500,000 for fiscal year 2000, and
4 \$52,500,000 for fiscal year 2001.

5 (B) With respect to awards to federally
6 qualified health centers (as defined in section
7 1861(aa)(4) of the Social Security Act) under
8 subpart B, there are authorized to be appro-
9 priated \$97,500,000 for fiscal year 1996,
10 \$227,500,000 for fiscal year 1997,
11 \$357,500,000 for fiscal year 1998,
12 \$292,500,000 for fiscal year 1999,
13 \$227,500,000 for fiscal year 2000, and
14 \$97,500,000 for fiscal year 2001.

15 (2) SUBPART C.—

16 (A) For the purpose of providing loans
17 under subpart C, there are authorized to be ap-
18 propriated such sums as may be necessary to
19 support a loan level of \$200,000,000 for each
20 of the fiscal years 1996 through 2001.

21 (B) For the purpose of making grants
22 under subpart C, there are authorized to be ap-
23 propriated \$35,000,000 for each of the fiscal
24 year 1996 through 2001.

1 (b) RELATION TO OTHER FUNDS.—The authoriza-
2 tions of appropriations established in subsection (a) are
3 in addition to any other authorizations of appropriations
4 that are available for the purpose described in such sub-
5 section.

6 (c) ELIGIBLE ENTITIES.—For purposes of this part,
7 the term “eligible entities” means—

8 (1) covered entities as defined in section
9 340B(a)(4) of the Public Health Service Act (42
10 U.S.C. 256b(a)(4)), except that subsection
11 (a)(4)(L)(iii) and (a)(7) of such section shall not
12 apply;

13 (2) nonprofit hospitals meeting the criteria for
14 public hospitals which are eligible entities under sec-
15 tion 340B of the Public Health Service Act, except
16 that subsection (a)(4)(L)(iii) of such section shall
17 not apply, and children’s hospitals meeting com-
18 parable criteria as determined appropriate by the
19 Secretary;

20 (3) public and private, nonprofit community
21 mental health centers and substance abuse treat-
22 ment providers receiving funds from the Substance
23 Abuse and Mental Health Services Administration;

24 (4) runaway homeless youth centers or transi-
25 tional living programs for homeless youth for the

1 provision of health services under the Runaway
2 Homeless Youth Act of 1974 (42 U.S.C. 5701 et
3 seq.);

4 (5) rural referral centers under section
5 1886(d)(5)(C) of the Social Security Act, except
6 that such eligibility is restricted to the receipt of
7 grants under section 3341; and

8 (6) public or nonprofit entities in
9 nonmetropolitan areas (as defined by the Depart-
10 ment of Commerce) in a consortium of community-
11 based providers that includes at least three of the
12 following:

13 (A) community or migrant health centers;

14 (B) local health departments;

15 (C) community mental health centers;

16 (D) nonprofit hospitals;

17 (E) private practice health professionals,
18 including rural health clinics; or

19 (F) other publicly funded health or social
20 services agencies.

21 (d) PRIORITY.—In making awards from amounts ap-
22 propriated under subsection (a)(1)(B) and section 3362,
23 the Secretary shall give the highest priority to providing
24 adequate assistance to federally qualified health centers
25 in order to ensure the provision of comprehensive primary

1 health care services, other covered services and benefits,
 2 and enabling services to medically underserved populations
 3 that were served by such centers prior to the date of enact-
 4 ment of this Act, except that such federally qualified
 5 health centers must continue to meet the requirements for
 6 designation under section 1861(aa)(4) of the Social Secu-
 7 rity Act.

8 (e) EQUITABLE DISTRIBUTION.—The Secretary
 9 shall, in awarding grants, entering into contracts, and
 10 making loans under this part, assure an equitable distribu-
 11 tion of funds between rural and urban areas.

12 **Subpart B—Development of Community Health**

13 **Groups and Health Care Sites and Services**

14 **SEC. 3321. GRANTS AND CONTRACTS FOR DEVELOPMENT**
 15 **OF PLANS AND NETWORKS AND THE EXPAN-**
 16 **SION AND DEVELOPMENT OF HEALTH CARE**
 17 **SITES AND SERVICES.**

18 (a) IN GENERAL.—The Secretary may make grants
 19 to and enter into contracts with eligible entities described
 20 in section 3311(c) for—

21 (1) the development of community health
 22 groups whose principal purpose is to provide the
 23 benefits required under subtitle B of title I in one
 24 or more health professional shortage areas or to pro-
 25 vide such items and services to a significant number

1 of individuals who are members of a medically un-
2 derserved population; and

3 (2) the expansion of existing health delivery
4 sites and services and the development of new health
5 delivery sites and services.

6 (b) SERVICE AREA.—In making an award under sub-
7 section (a), the Secretary shall designate the geographic
8 area with respect to which the community health group
9 involved is to provide health services.

10 (c) PRIORITY.—In making awards under subsection
11 (a)(1), the Secretary shall give priority to proposals in
12 which a greater number of eligible entities and other
13 health care providers are participants in the community
14 health group, except in areas such as rural areas, where
15 providers are severely limited in number.

16 (d) LIMITATION ON AWARDS.—The Secretary may
17 not make awards under subsection (a)(1) for more than
18 5 years to the same community health group.

19 (e) DEFINITIONS.—For purposes of this subpart:

20 (1) The term “community health group”
21 means—

22 (A) a community health network that—

23 (i) is a public or nonprofit private
24 consortium of health care providers that
25 principally provides some of the items and

1 services of the basic benefit package to
2 medically underserved populations, and
3 residents of health professional shortage
4 areas; and

5 (ii) has a written agreement governing
6 the participation of health care providers
7 in the consortium to which each participat-
8 ing provider is a party; or

9 (B) a community health plan that—

10 (i) is a public or nonprofit private en-
11 tity that principally provides all of the
12 items and services of the basic benefit
13 package to medically underserved popu-
14 lations, and residents of health professional
15 shortage areas;

16 (ii) is a participant in one or more
17 health alliances; and

18 (iii) has a written agreement govern-
19 ing the participation of health care provid-
20 ers in the consortium to which each par-
21 ticipating provider is a party.

22 (2) The term “health professional shortage
23 areas” means health professional shortage areas des-
24 ignated under section 332 of the Public Health Serv-
25 ice Act.

1 (3) The term “medically underserved popu-
2 lation” means a medically underserved population
3 designated under section 330(b)(3) of the Public
4 Health Service Act, populations residing in health
5 professional shortage areas under section 332 of the
6 Public Health Service Act, and populations eligible
7 for premium subsidies and cost sharing reductions
8 based on income under title I.

9 **SEC. 3322. CERTAIN USES OF AWARDS.**

10 (a) IN GENERAL.—Amounts awarded under section
11 3321 may be expended for—

12 (1) the development of a community health
13 group, including entering into contracts between the
14 recipient of the award and health care providers who
15 are to participate in the group;

16 (2) the expansion, development and on-going
17 operation of health delivery sites and services; and

18 (3) activities under paragraphs (1) and (2)
19 which include—

20 (A) the recruitment, compensation, and
21 training of health professionals and administra-
22 tive staff;

23 (B) the purchase and upgrading of equip-
24 ment, supplies, and information systems includ-
25 ing telemedicine systems; and

1 (C) the establishment of reserves required
2 for furnishing services on a prepaid or capitated
3 basis, except that eligible entities may use non-
4 cash mechanisms (including bonds, letters of
5 credit and federally guaranteed reinsurance
6 pools) for establishing and maintaining finan-
7 cial reserves.

8 (b) LOANS AND GRANTS.—The Secretary may ex-
9 pend, in any fiscal year, not to exceed 10 percent of the
10 amounts appropriated to carry out this subpart to make
11 loans and grants to eligible entities to support the types
12 of activities described in section 3341, subject to the re-
13 quirements of subpart C, except that, with respect to
14 amounts available for non-federally qualified health center
15 activities, such funds may be used to convert facilities
16 from providers of acute care service to providers of pri-
17 mary, emergency or long-term care.

18 **SEC. 3323. PURPOSES AND CONDITIONS.**

19 Grants shall be made under this subpart for the pur-
20 poses and subject to all of the conditions under which eli-
21 gible entities otherwise receive funding to provide health
22 services to medically underserved populations under the
23 Public Health Service Act. The Secretary shall prescribe
24 comparable purposes and conditions for eligible entities
25 not receiving funding under the Public Health Service Act.

1 **Subpart C—Capital Cost of Development of**
2 **Community Health Groups and Other Purposes**

3 **SEC. 3341. DIRECT LOANS AND GRANTS.**

4 (a) IN GENERAL.—The Secretary shall make grants
5 and loans to—

6 (1) eligible entities (as defined in section
7 3312(c));

8 (2) hospitals designated by the Secretary as es-
9 sential access community hospitals under section
10 1820(i)(1) of the Social Security Act; or

11 (3) rural primary care hospitals under section
12 1820(i)(2) of such Act;

13 for the capital costs of developing community health
14 groups (as defined in section 3321(e)) and expanding ex-
15 isting health delivery sites or developing new health deliv-
16 ery sites.

17 (b) USE OF ASSISTANCE.—

18 (1) IN GENERAL.—The capital costs for which
19 grants and loans made pursuant to subsection (a)
20 may be expended are, subject to paragraphs (2) and
21 (3), the following:

22 (A) The acquisition, modernization, expan-
23 sion or construction of facilities, or the conver-
24 sion of unneeded hospital facilities to facilities
25 that will assure or enhance the provision and

1 accessibility of health care and enabling services
2 to medically underserved populations.

3 (B) The purchase of major equipment, in-
4 cluding equipment necessary for the support of
5 external and internal information systems.

6 (C) The establishment of reserves required
7 for furnishing services on a prepaid or capitated
8 basis.

9 (D) Such other capital costs as the Sec-
10 retary may determine are necessary to achieve
11 the objectives of this section.

12 (2) PRIORITIES REGARDING USE OF FUNDS.—
13 In providing grants and loans under subsection (a)
14 for an entity, the Secretary shall give priority to au-
15 thorizing the use of amounts for projects for the
16 renovation and modernization of medical facilities
17 necessary to prevent or eliminate safety hazards in-
18 cluding asbestos removal, avoid noncompliance with
19 licensure or accreditation standards, or projects to
20 replace obsolete facilities.

21 (3) LIMITATION.—The Secretary may authorize
22 the use of grants and loans under subsection (a) for
23 the construction of new buildings only if the Sec-
24 retary determines that appropriate facilities are not
25 available through acquiring, modernizing, expanding

1 or converting existing buildings, or that construction
2 new buildings will cost less.

3 (c) AMOUNT OF ASSISTANCE.—

4 (1) IN GENERAL.—The principal amount of
5 loans under subsection (a) may cover up to 90 per-
6 cent of the costs involved.

7 (2) GRANTS.—Grants under this subsection
8 may not exceed 75 percent of the costs involved.

9 (d) INTEREST SUBSIDIES.—Amounts provided under
10 this section may be used to provide interest subsidies for
11 loans provided under this section where such subsidies are
12 necessary to make a project financial feasible.

13 **SEC. 3342. CERTAIN REQUIREMENTS.**

14 (a) IN GENERAL.—The Secretary may approve a loan
15 under section 3341 only if—

16 (1) the Secretary is reasonably satisfied that
17 the applicant for the project for which the loan
18 would be made will be able to make payments of
19 principal and interest thereon when due; and

20 (2) the applicant provides the Secretary with
21 reasonable assurances that there will be available to
22 it such additional funds as may be necessary to com-
23 plete the project or undertaking with respect to
24 which such loan is requested.

1 (b) TERMS AND CONDITIONS.—Any loan made under
2 section 3341 shall, subject to the Federal Credit Reform
3 Act of 1990, meet such terms and conditions (including
4 provisions for recovery in case of default) as the Secretary,
5 in consultation with the Secretary of the Treasury, deter-
6 mines to be necessary to carry out the purposes of such
7 section while adequately protecting the financial interests
8 of the United States. Terms and conditions for such loans
9 shall include provisions regarding the following:

10 (1) Security.

11 (2) Maturity date.

12 (3) Amount and frequency of installments.

13 (4) Rate of interest, which shall be at a rate
14 comparable to the rate of interest prevailing on the
15 date the loan is made.

16 **SEC. 3343. DEFAULTS; RIGHT OF RECOVERY.**

17 (a) DEFAULTS.—The Secretary may take such action
18 as may be necessary to prevent a default on loans under
19 section 3341, including the waiver of regulatory condi-
20 tions, deferral of loan payments, renegotiation of loans,
21 and the expenditure of funds for technical and consultative
22 assistance, for the temporary payment of the interest and
23 principal on such a loan, and for other purposes.

24 (b) FORECLOSURE.—The Secretary may take such
25 action, consistent with State law respecting foreclosure

1 procedures, as the Secretary deems appropriate to protect
2 the interest of the United States in the event of a default
3 on a loan made pursuant to section 3341, including selling
4 real property pledged as security for such a loan and for
5 a reasonable period of time taking possession of, holding,
6 and using real property pledged as security for such a
7 loan.

8 **SEC. 3344. APPLICATION FOR ASSISTANCE.**

9 The Secretary may provide loans under section 3341
10 only if an application for such assistance is submitted to
11 the Secretary, the application meets such requirements,
12 and the application is in such form, is made in such man-
13 ner, and contains such agreements, assurances, and infor-
14 mation as the Secretary determines to be necessary to
15 carry out this subpart.

16 **Subpart D—Enabling and Supplemental Services**

17 **SEC. 3361. GRANTS AND CONTRACTS FOR ENABLING AND**
18 **SUPPLEMENTAL SERVICES.**

19 (a) IN GENERAL.—The Secretary may make grants
20 to and enter into contracts with eligible entities to assist
21 such entities in providing the services described in sub-
22 sections (b) and (c) for the purpose of increasing the ca-
23 pacity of individuals to utilize the items and services in-
24 cluded in the benefits package required under title I, and
25 to provide access to essential supplemental services that

1 are not fully reimbursable under title I prior to January
2 2002.

3 (b) ENABLING SERVICES.—Enabling services shall
4 include transportation, community and patient outreach,
5 patient and family education, translation services, case
6 management, home visiting, and such other services as the
7 Secretary determines to be appropriate in carrying out the
8 purpose described in such subsection.

9 (c) SUPPLEMENTAL SERVICES.—Supplemental serv-
10 ices shall include items or services described in section
11 1101 of this Act that would otherwise be excluded from
12 coverage.

13 (d) CERTAIN REQUIREMENTS REGARDING PROJECT
14 AREA.—The Secretary may make an award of a grant or
15 contract under subsection (a) only if the applicant in-
16 volved—

17 (1) submits to the Secretary—

18 (A) information demonstrating that the
19 medically underserved populations in the com-
20 munity to be served under the award have a
21 need for enabling services; and

22 (B) a proposed budget for providing such
23 services;

24 (2) the applicant for the award agrees that the
25 medically underserved residents of the community

1 will be consulted with respect to the design and im-
2 plementation of the project carried out with the
3 award;

4 (3) agrees that the services will not be denied
5 because the individual is unable to pay for such serv-
6 ices; and

7 (4) agrees that the applicant will utilize existing
8 resources to the maximum extent practicable.

9 (e) APPLICATION FOR AWARDS OF ASSISTANCE.—
10 The Secretary may make an award of a grant or contract
11 under subsection (a) only if an application for the award
12 is submitted to the Secretary, the application contains
13 each agreement described in this subpart, and the applica-
14 tion is in such form, is made in such manner, and contains
15 such agreements, assurances, and information as the Sec-
16 retary determines to be necessary to carry out this sub-
17 part.

18 **SEC. 3362. AUTHORIZATIONS OF APPROPRIATIONS.**

19 (a) ENABLING SERVICES.—For the purpose of carry-
20 ing out section 3361(b), there are authorized to be appro-
21 priated \$35,000,000 for fiscal year 1997, \$140,000,000
22 for each of the fiscal years 1998 through 2000, and
23 \$175,000,000 for fiscal year 2001.

24 (b) SUPPLEMENTAL SERVICES.—For the purpose of
25 carrying out section 3361(c), there are authorized to be

1 appropriated \$100,000,000 for fiscal year 1996,
2 \$150,000,000 for fiscal year 1997, and \$250,000,000 for
3 each of the fiscal years 1998 through 2001.

4 (c) **FEDERALLY QUALIFIED HEALTH CENTERS.**—
5 With respect to federally qualified health centers (as de-
6 fined in section 1861(aa)(4) of the Social Security Act),
7 for the purpose of carrying out section 3361(b), there are
8 authorized to be appropriated \$65,000,000 for fiscal year
9 1997, \$260,000,000 for each of the fiscal years 1998
10 through 2000, and \$325,000,000 for fiscal year 2001.

11 (d) **RELATION TO OTHER FUNDS.**—The authoriza-
12 tions of appropriations established in subsection (a) are
13 in addition to any other authorizations of appropriations
14 that are available for the purpose described in such sub-
15 section.

16 **PART 2—NATIONAL HEALTH SERVICE CORPS**

17 **SEC. 3371. AUTHORIZATIONS OF APPROPRIATIONS.**

18 (a) **ADDITIONAL FUNDING; GENERAL CORPS PRO-**
19 **GRAM; ALLOCATIONS REGARDING NURSES.**—For the pur-
20 pose of carrying out subpart II of part D of title III of
21 the Public Health Service Act, and for the purpose of car-
22 rying out section 3372, there are authorized to be appro-
23 priated \$150,000,000 for fiscal year 1997, \$150,000,000
24 for fiscal year 1998, and \$250,000,000 for each of the
25 fiscal years 1999 through 2001.

1 (b) RELATION TO OTHER FUNDS.—The authoriza-
2 tions of appropriations established in subsection (a) are
3 in addition to any other authorizations of appropriations
4 that are available for the purpose described in such sub-
5 section.

6 **SEC. 3372. ALLOCATION FOR PARTICIPATION OF NURSES**
7 **IN SCHOLARSHIP AND LOAN REPAYMENT**
8 **PROGRAMS.**

9 Of the amounts appropriated under section 3371, the
10 Secretary shall reserve such amounts as may be necessary
11 to ensure that, of the aggregate number of individuals who
12 are participants in the Scholarship Program under section
13 338A of the Public Health Service Act, or in the Loan
14 Repayment Program under section 338B of such Act, the
15 total number who are being educated as nurse practition-
16 ers, nurse midwives, or nurse anesthetists or are serving
17 as nurse practitioners, nurse midwives, or nurse anes-
18 thetists, respectively, is increased to 20 percent.

19 **SEC. 3373. ALLOCATION FOR PARTICIPATION OF PSYCHIA-**
20 **TRISTS, PSYCHOLOGISTS, AND CLINICAL SO-**
21 **CIAL WORKERS IN SCHOLARSHIP AND LOAN**
22 **REPAYMENT PROGRAMS.**

23 Of the amounts appropriate under section 3371, the
24 Secretary shall reserve such amounts as may be necessary
25 to ensure that of the aggregate number of individuals who

1 are participants in the scholarship program under section
2 338A of the Public Health Service Act, the number who
3 are being educated as psychiatrists, psychologists, and
4 clinical social workers or are serving as psychiatrists, psy-
5 chologists, and clinical social workers, respectively, is in-
6 creased to 15 percent.

7 **PART 3—PAYMENTS TO HOSPITALS SERVING**
8 **VULNERABLE POPULATIONS**

9 **SEC. 3381. PAYMENTS TO HOSPITALS.**

10 (a) ENTITLEMENT STATUS.—The Secretary shall
11 make payments in accordance with this part to eligible
12 hospitals described in section 3382. The preceding sen-
13 tence—

14 (1) is an entitlement in the Secretary on behalf
15 of such eligible hospitals (but is not an entitlement
16 in the State in which any such hospital is located or
17 in any individual receiving services from any such
18 hospital); and

19 (2) constitutes budget authority in advance of
20 appropriations Acts and represents the obligation of
21 the Federal Government to provide funding for such
22 payments in the amounts, and for the fiscal years,
23 specified in subsection (b).

24 (b) APPROPRIATIONS.—

1 (1) IN GENERAL.—For purposes of subsection
2 (a)(2), the amounts and fiscal years specified in this
3 subsection are (in the aggregate for all eligible hos-
4 pitals) \$1,300,000,000 for the fiscal year in which
5 the general effective date occurs and for each subse-
6 quent fiscal year.

7 (2) SPECIAL RULE FOR YEARS BEFORE GEN-
8 ERAL EFFECTIVE DATE.—

9 (A) IN GENERAL.—For each of the fiscal
10 years 1997 and 1998, the amount specified in
11 this subsection for purposes of subsection (a)(2)
12 shall be equal to the aggregate DSH percentage
13 of the amount otherwise determined under
14 paragraph (1).

15 (B) AGGREGATE DSH PERCENTAGE DE-
16 FINED.—In subparagraph (A), the “aggregate
17 DSH percentage” for a year is the amount (ex-
18 pressed as a percentage) equal to—

19 (i) the total amount of payment made
20 by the Secretary under section 1903(a) of
21 the Social Security Act during the base
22 year with respect to payment adjustments
23 made under section 1923(c) of such Act
24 for hospitals in the States in which eligible

1 hospitals for the year are located; divided
2 by

3 (ii) the total amount of payment made
4 by the Secretary under section 1903(a) of
5 such Act during the base year with respect
6 to payment adjustments made under sec-
7 tion 1923(c) of such Act for hospitals in
8 all States.

9 (c) PAYMENTS MADE ON QUARTERLY BASIS.—Pay-
10 ments to an eligible hospital under this section for a year
11 shall be made on a quarterly basis during the year.

12 **SEC. 3382. IDENTIFICATION OF ELIGIBLE HOSPITALS.**

13 (a) STATE IDENTIFICATION.—In accordance with the
14 criteria described in subsection (b) and such procedures
15 as the Secretary may require, each State shall identify the
16 hospitals in the State that meet such criteria and provide
17 the Secretary with a list of such hospitals.

18 (b) CRITERIA FOR ELIGIBILITY.—A hospital meets
19 the criteria described in this subsection if the hospital's
20 low-income utilization rate for the base year under section
21 1923(b)(3) of the Social Security Act (as such section is
22 in effect on the day before the date of the enactment of
23 this Act) is not less than 25 percent.

1 **SEC. 3383. AMOUNT OF PAYMENTS.**

2 (a) DISTRIBUTION OF ALLOCATION FOR LOW-IN-
3 COME ASSISTANCE.—

4 (1) ALLOCATION FROM TOTAL AMOUNT.—Of
5 the total amount available for payments under this
6 section in a year, 66.66 percent shall be allocated to
7 hospitals for low-income assistance in accordance
8 with this subsection.

9 (2) DETERMINATION OF HOSPITAL PAYMENT
10 AMOUNT.—The amount of payment to an eligible
11 hospital from the allocation made under paragraph
12 (1) during a year shall be the equal to the hospital's
13 low-income percentage of the allocation for the year.

14 (b) DISTRIBUTION OF ALLOCATION FOR ASSISTANCE
15 FOR UNCOVERED SERVICES.—

16 (1) ALLOCATION FROM TOTAL AMOUNT; DETER-
17 MINATION OF STATE-SPECIFIC PORTION OF ALLOCA-
18 TION.—Of the total amount available for payments
19 under this section in a year, 33.33 percent shall be
20 allocated to hospitals for assistance in furnishing
21 hospital services that are not covered services under
22 title I (in accordance with regulations of the Sec-
23 retary) or in furnishing hospital services to individ-
24 uals, including those residing in Southwestern bor-
25 der States, who are not eligible individuals under
26 title I, in accordance with this subsection. The

1 amount available for payments to eligible hospitals
2 in a State shall be equal to an amount determined
3 in accordance with a methodology specified by the
4 Secretary that shall take into consideration the vol-
5 ume of such services provided by hospitals in the
6 State as compared to the volume of such services
7 provided by all eligible hospitals.

8 (2) DETERMINATION OF HOSPITAL PAYMENT
9 AMOUNT.—The amount of payment to an eligible
10 hospital in a State from the amount available for
11 payments to eligible hospitals in the State under
12 paragraph (1) during a year shall be the equal to
13 the hospital's low-income percentage of such amount
14 for the year.

15 (c) LOW-INCOME PERCENTAGE DEFINED.—

16 (1) IN GENERAL.—In this subsection, an eligi-
17 ble hospital's "low-income percentage" for a year is
18 equal to the amount (expressed as a percentage) of
19 the total low-income days for all eligible hospitals for
20 the year that are attributable to the hospital.

21 (2) LOW-INCOME DAYS DESCRIBED.—For pur-
22 poses of paragraph (1), an eligible hospital's low-in-
23 come days for a year shall be equal to the product
24 of—

1 (A) the total number of inpatient days for
2 the hospital for the year (as reported to the
3 Secretary by the State in which the hospital is
4 located, in accordance with a reporting schedule
5 and procedures established by the Secretary);
6 and

7 (B) the hospital's low-income utilization
8 rate for the base year under section 1923(b)(3)
9 of the Social Security Act (as such section is in
10 effect on the day before the date of the enact-
11 ment of this Act).

12 **SEC. 3384. BASE YEAR.**

13 In this part, the "base year" is, with respect to a
14 State and hospitals in a State, the year immediately prior
15 to the year in which the general effective date occurs.

16 **PART 4—SENSE OF THE COMMITTEE**

17 **SEC. 3391. SENSE OF THE COMMITTEE.**

18 It is the sense of the Committee on Labor and
19 Human Resources of the Senate that when the Affordable
20 Health Care for All Americans Act is enacted, it and sub-
21 sequent appropriations Acts should appropriately recog-
22 nize the success of community and migrant health centers
23 as a proven, cost-effective model for the delivery of health
24 care services to those populations which are medically un-

1 derserved because of economic, geographic, and cultural
2 barriers.

3 **Subtitle D—Assistance For State**
4 **Managed Mental Health And**
5 **Substance Abuse Programs**

6 **SEC. 3431. AVAILABILITY OF ASSISTANCE.**

7 (a) IN GENERAL.—The Secretary shall make grants
8 to States for the development and operation of comprehen-
9 sive managed mental health and substance abuse pro-
10 grams that are integrated with the health delivery system
11 established under this Act. Such programs shall—

12 (1) promote the development of integrated de-
13 livery systems for the management of the mental
14 health and substance abuse services provided under
15 the comprehensive benefits package;

16 (2) give priority to providing services to low-in-
17 come adults with serious mental illness or substance
18 abuse disorders and children with serious emotional
19 disturbance or substance abuse disorders and pro-
20 vide for the phase-in of such services for all eligible
21 persons within 5 years;

22 (3) ensure that individuals participating in the
23 program have access to all medically necessary men-
24 tal health and substance abuse services;

1 (4) promote the linkage of mental health and
2 substance abuse services with primary and preven-
3 tive health care services; and

4 (5) meet such other requirements as the Sec-
5 retary may impose.

6 (b) EXCEPTION.—Nothing in this subtitle shall be
7 construed as preventing States that have separate admin-
8 istrative entities for mental health and for substance abuse
9 services from establishing separate comprehensive man-
10 aged care programs for such services and receiving assist-
11 ance under this subtitle for either or both programs.

12 **SEC. 3432. PLAN REQUIREMENTS.**

13 In order to receive a grant under this subtitle, a State
14 must have a plan for a comprehensive managed mental
15 health and substance abuse program which is approved
16 by the Secretary. Such plan shall—

17 (1) describe the management, access, and refer-
18 ral structure that the State will use to promote and
19 achieve integration of mental health and substance
20 abuse services with the health delivery system estab-
21 lished under this Act for eligible individuals in the
22 State;

23 (2) describe how the State will ensure that pro-
24 viders of specialized services will meet appropriate
25 standards;

1 (3) describe payment, utilization review, and
2 other mechanisms that the State will use to encour-
3 age appropriate service delivery and management of
4 costs;

5 (4) describe uniform patient placement criteria
6 that the State will use to ensure placement in appro-
7 priate substance abuse treatment programs;

8 (5) describe the processes the State will use to
9 ensure that individuals will continue to have access
10 to treatment through referrals from nonhealth public
11 entities, such as the juvenile or criminal justice sys-
12 tems, or social service systems;

13 (6) specify the methods the State will use to en-
14 sure that individuals receiving services under the
15 program have access to all medically necessary and
16 appropriate mental health and substance abuse serv-
17 ices;

18 (7) define terms that will be used by the State
19 in determining the eligibility of individuals for serv-
20 ices under the program;

21 (8) describe how health plans will use services
22 under the comprehensive managed mental health
23 and substance abuse programs established under
24 this subtitle;

1 (9) describe the role of local government in fi-
2 nancing and managing the integrated mental illness
3 and substance abuse treatment system;

4 (10) describe the sources of funding, including
5 Medicaid and the block grants authorized by title
6 XIX of the Public Health Service Act, that will be
7 used by the State, other than the grant received
8 under this subtitle, to operate the program, and pro-
9 vide the status of any request for a Medicaid waiver
10 made by the State to the Secretary;

11 (11) describe how the State provided for broad-
12 based public input in the development of the plan,
13 and the mechanism that will be used for ongoing
14 public comment on and review of amendments to the
15 plan; and

16 (12) describe grievance procedures that will be
17 available for individuals dissatisfied with their health
18 plan's participation in the comprehensive managed
19 mental health and substance abuse program, and
20 mechanisms that will be available to review the per-
21 formance of health plans and fee-for-service arrange-
22 ments to ensure against under treatment.

23 **SEC. 3433. ADDITIONAL FEDERAL RESPONSIBILITIES.**

24 The Secretary shall, upon the submission of a State's
25 plan under section 3432, ensure the timely consideration

1 of any Medicaid waiver requests submitted by the State,
 2 affirm that **[section 1504]** has been implemented, and
 3 ensure the timely implementation of **[section**
 4 **1641(b)(5)]**.

5 **SEC. 3434. AUTHORIZATION OF APPROPRIATIONS.**

6 There are authorized to be appropriated for grants
 7 under this subtitle, \$100,000,000 for each of the fiscal
 8 years 1996 through 2001.

9 **Subtitle E—Comprehensive School**
 10 **Health Education; School-Relat-**
 11 **ed Health Services**

12 **PART 1—HEALTHY STUDENTS-HEALTHY**
 13 **SCHOOLS GRANTS FOR SCHOOL HEALTH**
 14 **EDUCATION**

15 **SEC. 3501. PURPOSES.**

16 It is the purpose of this part—

17 (1) to support the development and implemen-
 18 tation of comprehensive age appropriate health edu-
 19 cation programs in public schools for children and
 20 youth kindergarten through grade 12; and

21 (2) to increase access to preventive and primary
 22 health care services for children and youth through
 23 school-based or school-linked health service sites in
 24 accordance with locally determined needs.

1 **SEC. 3502. HEALTHY STUDENTS-HEALTHY SCHOOLS**
2 **GRANTS.**

3 (a) IN GENERAL.—The Secretary, in consultation
4 with the Secretary of Education, shall award grants to
5 State educational agencies in eligible States to integrate
6 comprehensive school health education in schools within
7 the State, with priority given within States to those com-
8 munities in greatest need as defined by section 3583(a).

9 (b) ELIGIBLE USES OF FUNDS.—Funds made avail-
10 able under this section shall be used—

11 (1) to implement comprehensive school health
12 education programs, as defined in subsection (f)(1)
13 through grants to local educational agencies;

14 (2) to provide staff development and technical
15 assistance to local educational agencies, schools,
16 local health agencies, and other community organiza-
17 tions involved in providing comprehensive school
18 health education programs;

19 (3) to evaluate and report to the Secretary on
20 the progress made towards attaining the goals and
21 objectives described under subsection (c)(1)(A); and

22 (4) to conduct such other activities to achieve
23 the objectives of this subpart as the Secretary may
24 require.

25 (c) APPLICATION.—An application for a grant under
26 subsection (a), shall be jointly developed by the State edu-

1 cational agency and the State health agencies of the State
2 involved, and shall contain—

3 (1) a State plan for comprehensive school
4 health education programs, that outlines—

5 (A) the goals and objectives of the State
6 for school health education programs, and the
7 manner in which the State will allocate funds to
8 local educational agencies in order to achieve
9 these goals and objectives;

10 (B) the manner in which the State will co-
11 ordinate programs under this part with other
12 Federal, State and local health education pro-
13 grams and resources, and school health serv-
14 ices;

15 (C) the manner in which comprehensive
16 school health education programs will be coordi-
17 nated with other Federal, State and local edu-
18 cation programs (such as programs under titles
19 I, II, and IV of the Elementary and Secondary
20 Education Act of 1965), with the school im-
21 provement plan of the State, if any, under title
22 III of the Goals 2000: Educate America Act,
23 and with any similar programs;

24 (D) the manner in which the State shall
25 work with State and local educational agencies

1 and with State and local health agencies to re-
2 duce barriers to implementing school health
3 education programs;

4 (E) the manner in which the State will
5 monitor the implementation of such programs
6 by local educational agencies and establish out-
7 come criteria by which to evaluate their effec-
8 tiveness in achieving progress towards the goals
9 and objectives described in subparagraph (A);

10 (F) the manner in which the State will
11 provide staff development and technical assist-
12 ance to local educational agencies, and build ca-
13 pacity for professional development of health
14 educators; and

15 (G) the manner in which such school
16 health education programs will be, to the extent
17 practicable, culturally competent and linguis-
18 tically appropriate and responsive to the diverse
19 needs of the students served;

20 (2) a description of the respective roles of the
21 State educational agency, local educational agencies,
22 the State health agency and local health agencies in
23 developing and implementing the State's school
24 health education plan and resulting programs;

1 (3) a description of the input of the local com-
2 munity (including students and parents) in the de-
3 velopment and operation of comprehensive school
4 health education programs;

5 (4) an assurance that communities identified in
6 section 3583 receive priority as locations for com-
7 prehensive school health education programs for all
8 grades to the extent that a State does not implement
9 a statewide program; and

10 (5) an assurance that grants to local edu-
11 cational agencies under subsection (b)(1) are contin-
12 gent upon submission by such agencies of a plan
13 consistent with the requirements for the State plan
14 as required under this subsection.

15 (d) WAIVERS OF STATUTORY AND REGULATORY RE-
16 QUIREMENTS.—

17 (1) WAIVERS.—Except as provided in para-
18 graph (4), upon the request of an entity and under
19 a relevant program described in paragraph (2), the
20 Secretary of Health and Human Services and the
21 Secretary of Education may grant to the entity a
22 waiver of any requirement of such program regard-
23 ing the use of funds, or of the regulations issued for
24 the program by the Secretary involved, if the follow-
25 ing conditions are met with respect to such program:

1 (A) The Secretary involved determines that
2 the requirements of such program impede the
3 ability of the State educational agency to
4 achieve more effectively the purposes described
5 in section 3501.

6 (B) The Secretary involved determines
7 that, with respect to the use of funds under
8 such program, the requested use of the funds
9 by the entity would be consistent with the pur-
10 poses described in section 3501.

11 (C) The State educational agency provides
12 all interested local educational agencies in the
13 State with notice and an opportunity to com-
14 ment on the proposal and makes these com-
15 ments available to the Secretary.

16 (2) RELEVANT PROGRAMS.—For purposes of
17 paragraph (1), the programs described in this sub-
18 paragraph are the following:

19 (A) In the case of programs administered
20 by the Secretary of Health and Human Serv-
21 ices, the following:

22 (i) The program known as the Preven-
23 tion, Treatment, and Rehabilitation Model
24 Projects for High Risk Youth, carried out

1 under section 517 of the Public Health
2 Service Act.

3 (ii) The program known as the State
4 and Local Comprehensive School Health
5 Programs to Prevent Important Health
6 Problems and Improve Educational Out-
7 comes, carried out under such Act.

8 (B) In the case of programs administered
9 by the Secretary of Education, any program
10 carried out under part B of the Drug-Free
11 Schools and Communities Act of 1986, except
12 that a component of such comprehensive school
13 health education must be consistent with the
14 statutory intent and purposes of such Act.

15 (3) WAIVER PERIOD.—A waiver under this
16 paragraph shall be for a period not to exceed 3
17 years, unless the Secretary involved determines
18 that—

19 (A) the waiver has been effective in ena-
20 bling the State to carry out the activities for
21 which it was requested and has contributed to
22 improved performance of comprehensive health
23 education programs; and

24 (B) such extension is in the public interest;

1 (4) WAIVERS NOT AUTHORIZED.—The Sec-
2 retary involved under paragraph (1), may not waive,
3 under this section, any statutory or regulatory re-
4 quirements relating to—

5 (A) comparability of services;

6 (B) maintenance of effort;

7 (C) parental participation and involvement;

8 (D) the distribution of funds to States or
9 to local educational agencies or other recipients
10 of funds under the programs described in para-
11 graph (2);

12 (E) maintenance of records;

13 (F) applicable civil rights requirements; or

14 (G) the requirements of sections 438 and
15 439 of the General Education Provisions Act.

16 (5) TERMINATION OF WAIVER.—The Secretary
17 involved under paragraph (1) shall terminate a waiv-
18 er under this subsection if the Secretary determines
19 that the performance of the State affected by the
20 waiver has been inadequate to justify a continuation
21 of the waiver or if it is no longer necessary to
22 achieve its original purpose.

23 (e) DEFINITIONS.—As used in this section:

24 (1) COMPREHENSIVE SCHOOL HEALTH EDU-
25 CATION.—The term “comprehensive school health

1 education” means a planned, sequential program of
2 health education that addresses the physical, emo-
3 tional and social dimensions of student health in
4 kindergarten through grade 12. Such program
5 shall—

6 (A) be designed to assist students in devel-
7 oping the knowledge and behavioral skills need-
8 ed to make positive health choices and maintain
9 and improve their health, prevent disease and
10 injuries, and reduce risk behaviors which ad-
11 versely impact health;

12 (B) be comprehensive and include a variety
13 of components addressing personal health, com-
14 munity and environmental health, injury pre-
15 vention and safety, nutritional health, the ef-
16 fects of substance use and abuse, consumer
17 health regarding the benefits and appropriate
18 use of medical services including immunizations
19 and other clinical preventive services, and other
20 components deemed appropriate by the local
21 educational agencies;

22 (C) be designed to be linguistically and cul-
23 turally competent and responsive to the needs
24 of the students served; and

1 (D) address locally relevant priorities as
2 determined by parents, students, teachers, and
3 school administrators and health officials.

4 (2) ELIGIBLE STATE.—The term “eligible
5 State” means a State with a memorandum of under-
6 standing or a written cooperative agreement entered
7 into by the agencies responsible for health and edu-
8 cation concerning the planning and implementation
9 of comprehensive school health education programs.
10 Among these States a priority shall be given to
11 qualified States as defined in section 3582(c).

12 (3) STATE EDUCATIONAL AGENCY.—The term
13 “State educational agency” means the officer or
14 agency primarily responsible for the State super-
15 vision of public elementary and secondary schools.

16 (4) LOCAL EDUCATIONAL AGENCY.—The term
17 “local educational agency” means a public board of
18 education or other public authority legally con-
19 stituted within a State for either administrative con-
20 trol or direction of, or to perform a service function
21 for, public elementary or secondary schools in a city,
22 county, township, school district, or other political
23 subdivision of a State, or such combination of school
24 districts or counties as are recognized in a State as
25 an administrative agency for its public elementary or

1 secondary schools. Such term includes any other
2 public institution or agency having administrative
3 control and direction of a public elementary or sec-
4 ondary school.

5 (f) AUTHORIZED FUNDING.—For the purpose of car-
6 rying out this section, out of the funds available under
7 section 3581, there are made available, not to exceed
8 \$15,000,000 for fiscal year 1996, \$20,000,000 for fiscal
9 year 1997, \$25,000,000 for fiscal year 1998, \$30,000,000
10 for fiscal year 1999, \$40,000,000 for fiscal year 2000, and
11 \$50,000,000 for fiscal year 2001.

12 **SEC. 3503. HEALTHY STUDENTS-HEALTHY SCHOOLS INTER-**
13 **AGENCY TASK FORCE.**

14 (a) ESTABLISHMENT.—Not later than 120 days after
15 the date of enactment of this Act, the Secretary shall es-
16 tablish a Healthy Students-Healthy Schools Interagency
17 Task Force to be composed of representatives of the Office
18 of Disease Prevention and Health Promotion, the National
19 Institutes of Health, the Centers for Disease Control and
20 Prevention, the Health Resources and Services Adminis-
21 tration, the Office of School Health Education within the
22 Department of Education, and other Federal agencies and
23 departments which have responsibility for components of
24 school health and education.

1 (b) CO-CHAIRPERSONS.—The Assistant Secretary for
2 Health and the Assistant Secretary for Elementary and
3 Secondary Education shall serve as co-chairpersons of the
4 task force established under subsection (a).

5 (c) FUNCTIONS AND ACTIVITIES.—The task force es-
6 tablished under subsection (a) shall—

7 (1) review and coordinate all Federal efforts in
8 school health education and health services;

9 (2) provide scientific and technical advice con-
10 cerning the development and implementation of
11 model comprehensive school health education pro-
12 grams and curricula;

13 (3) develop model student learning objectives
14 and assessment instruments that shall be made
15 available to all States;

16 (4) develop a uniform grant application form (a
17 form that serves as the principal document contain-
18 ing the core information concerning a particular en-
19 tity) and procedures that may be used with respect
20 to all school health education-related programs (in-
21 cluding supplementary information procedures to be
22 implemented when an entity that has already sub-
23 mitted an application form is applying for additional
24 assistance) that require the submission of an appli-
25 cation; and

1 (5) recommend to the Secretary, for inclusion
2 in the biennial report required by section 3504(2),
3 methods for effectively linking school health edu-
4 cation and health services research findings at the
5 Federal level with implementation at the State and
6 local levels.

7 (d) CONSOLIDATION OF INITIATIVES.—Not later
8 than 12 months after the date of enactment of this Act,
9 the task force established under subsection (a) shall pre-
10 pare and submit to the Congress a report containing the
11 recommendations of the task force for the consolidation
12 of Federal school health education initiatives.

13 **SEC. 3504. DUTIES OF THE SECRETARY.**

14 The Secretary shall—

15 (1) establish and maintain a national clearing-
16 house, using advanced technologies to the maximum
17 extent practicable, and mechanisms for the diverse
18 dissemination of school health education material,
19 including written, audio-visual, and electronically
20 conveyed information to educators, schools, health
21 care providers, and other individuals, organizations,
22 and governmental entities;

23 (2) submit a biennial report to the Committee
24 on Labor and Human Resources of the Senate and
25 the appropriate committees of the House of Rep-

1 representatives on the implementation and contribution
 2 of comprehensive school health education programs
 3 funded under this part toward achieving relevant
 4 National Healthy People 2000 objectives established
 5 by the Secretary; and

6 (3) encourage coordination among Federal
 7 agencies, State and local governments, educators,
 8 school health providers, community-based organiza-
 9 tions, and private sector entities to support develop-
 10 ment of comprehensive school health education pro-
 11 grams and school health services.

12 **PART 5—SCHOOL-RELATED HEALTH SERVICES**

13 **Subpart A—Development and Operation**

14 **SEC. 3581. AUTHORIZATION OF APPROPRIATIONS.**

15 (a) FUNDING FOR SCHOOL-RELATED HEALTH SERV-
 16 ICES.—For the purpose of carrying out this subpart, there
 17 are authorized to be appropriated \$100,000,000 for fiscal
 18 year 1996, \$200,000,000 for fiscal year 1997,
 19 \$325,000,000 for fiscal year 1998, \$450,000,000 for fis-
 20 cal year 1999, \$575,000,000 for fiscal year 2000, and
 21 \$700,000,000 for fiscal year 2001.

22 (b) FUNDING FOR PLANNING AND DEVELOPMENT
 23 GRANTS.—Of amounts made available under this section,
 24 not to exceed \$10,000,000 for each of fiscal years 1996
 25 and 1997 may be utilized to carry out section 3584.

1 **SEC. 3582. ELIGIBILITY FOR GRANTS.**

2 (a) IN GENERAL.—

3 (1) PLANNING AND DEVELOPMENT GRANTS.—

4 Entities eligible to apply for and receive grants
5 under section 3584 are—

6 (A) State health agencies that apply on be-
7 half of local community partnerships; or

8 (B) local community partnerships in States
9 in which health agencies have not successfully
10 applied.

11 (2) OPERATIONAL GRANTS.—Entities eligible to
12 apply for and receive grants under section 3585
13 are—

14 (A) a qualified State as designated under
15 subsection (c) that apply on behalf of local com-
16 munity partnerships; or

17 (B) local community partnerships in States
18 that are not designated under subparagraph
19 (A).

20 (b) LOCAL COMMUNITY PARTNERSHIPS.—

21 (1) IN GENERAL.—A local community partner-
22 ship under subsection (a)(1)(B) and (a)(2)(B) is an
23 entity that, at a minimum includes—

24 (A) a local health care provider, which may
25 be a local public health department, with expe-

1 rience in delivering services to children and
2 youth or medically underserved populations;

3 (B) local educational agency on behalf of
4 one or more public schools; and

5 (C) one community-based organization lo-
6 cated in the community to be served that has
7 a history of providing services to at-risk chil-
8 dren and youth.

9 (2) RURAL COMMUNITIES.—In rural commu-
10 nities, local partnerships should seek to include, to
11 the fullest extent practicable, providers and commu-
12 nity-based organizations with experience in serving
13 the target population.

14 (3) PARENT AND COMMUNITY PARTICIPA-
15 TION.—An applicant described in subsection (a)
16 shall, to the maximum extent feasible, involve broad-
17 based community participation (including parents of
18 the youth to be served).

19 (c) QUALIFIED STATE.—A qualified State under sub-
20 section (a)(2)(A) is a State that, at a minimum—

21 (1) demonstrates an organizational commitment
22 (including a strategic plan) to providing a broad
23 range of health, health education and support serv-
24 ices to at-risk youth; and

1 (2) has a memorandum of understanding or co-
2 operative agreement jointly entered into by the State
3 agencies responsible for health and education re-
4 garding the planned delivery of health and support
5 services in school-based or school-linked centers.

6 **SEC. 3583. PREFERENCES.**

7 In making grants under sections 3584 and 3585, the
8 Secretary shall give priority to applicants whose commu-
9 nities to be served show the most substantial level of need
10 for health services among children and youth.

11 **SEC. 3584. PLANNING AND DEVELOPMENT GRANTS.**

12 (a) IN GENERAL.—The Secretary may make grants
13 during fiscal years 1996 and 1997 to entities eligible
14 under section 3862 to develop school-based or school-
15 linked health service sites.

16 (b) USE OF FUNDS.—Amounts provided under a
17 grant under this section may be used for the following:

18 (1) Planning for the provision of school health
19 services, including—

20 (A) an assessment of the need for health
21 services among youth in the communities to be
22 served;

23 (B) the health services to be provided and
24 how new services will be integrated with exist-
25 ing services;

1 (C) assessing and planning for the mod-
2 ernization and expansion of existing facilities
3 and equipment to accommodate such services;
4 and

5 (D) an affiliation with relevant health
6 plans.

7 (2) recruitment and training of staff for the ad-
8 ministration and delivery of school health services;

9 (3) the establishment of local community part-
10 nerships as described in section 3582 (b);

11 (4) in the case of States, the development of
12 memorandums of understanding or cooperative
13 agreements for the coordinated delivery of health
14 and support services through school health service
15 sites; and

16 (5) other activities necessary to assume oper-
17 ational status.

18 (c) APPLICATION FOR GRANTS.—To be eligible to re-
19 ceive a grant under this section an entity described in sec-
20 tion 3582(a) shall submit an application in a form and
21 manner prescribed by the Secretary.

22 (d) NUMBER OF GRANTS.—Not more than one plan-
23 ning grant may be made to a single applicant. A planning
24 grant may not exceed 2 years in duration.

1 (e) AMOUNT AVAILABLE FOR DEVELOPMENT
2 GRANT.—The Secretary may award not to exceed—

3 (1) \$150,000 to entities under section
4 3582(a)(1)(A) and to localities planning for a city-
5 wide or countywide school health services delivery
6 system; and

7 (2) \$50,000 to entities under section
8 3582(a)(1)(B).

9 **SEC. 3585. GRANTS FOR OPERATION OF SCHOOL HEALTH**
10 **SERVICES.**

11 (a) IN GENERAL.—The Secretary may make grants
12 to eligible entities described in section 3582(a)(2) that
13 submit applications consistent with the requirements of
14 this section, to pay the cost of operating school-based or
15 school-linked health service sites.

16 (b) USE OF GRANT.—Amounts provided under a
17 grant under this section may be used for the following—

18 (1) health services, including diagnosis and
19 treatment of simple illnesses and minor injuries;

20 (2) preventive health services, including health
21 screenings, follow-up health care, mental health, and
22 preventive health education;

23 (3) enabling services, as defined in section
24 3361, and other necessary support services;

1 (4) training, recruitment, and compensation of
2 health professionals and other staff necessary for the
3 administration and delivery of school health services;
4 and

5 (5) referral services, including the linkage of in-
6 dividuals to health plans, and community-based
7 health and social service providers.

8 (c) APPLICATION FOR GRANT.—To be eligible to re-
9 ceive a grant under this section an entity described in sec-
10 tion 3582(a)(2) shall submit an application in a form and
11 manner prescribed by the Secretary. In order to receive
12 a grant under this section, an applicant must include in
13 the application the following information—

14 (1) a description of the services to be furnished
15 by the applicant;

16 (2) the amounts and sources of funding that
17 the applicant will expend, including estimates of the
18 amount of payments the applicant will receive from
19 health plans and other sources;

20 (3) a description of local community partner-
21 ships, including parent and community participation;

22 (4) a description of the linkages with other
23 health and social service providers; and

24 (5) such other information as the Secretary de-
25 termines to be appropriate.

1 (d) ASSURANCES.—In order to receive a grant under
2 this section, an applicant must meet the following condi-
3 tions—

4 (1) school health service sites will, directly or
5 indirectly, provide a broad range of health services,
6 in accordance with the determinations of the local
7 community partnership, that may include—

8 (A) diagnosis and treatment of simple ill-
9 nesses and minor injuries;

10 (B) preventive health services, including
11 health screenings and follow-up health care,
12 mental health and preventive health education;

13 (C) enabling services, as defined in section
14 3361;

15 (D) referrals (including referrals regarding
16 mental health and substance abuse) with follow-
17 up to ensure that needed services are received;

18 (2) the applicant provides services rec-
19 ommended by the health provider, in consultation
20 with the local community partnership, and with the
21 approval of the local education agency;

22 (3) the applicant provides the services under
23 this subsection to adolescents, and other school age
24 children and their families as deemed appropriate by
25 the local partnership;

1 (4) the applicant maintains agreements with
2 community-based health care providers with a his-
3 tory of providing services to such populations for the
4 provision of health care services not otherwise pro-
5 vided directly or during the hours when school
6 health services are unavailable;

7 (5) the applicant establishes an affiliation with
8 relevant health plans and will establish reimburse-
9 ment procedures and will make every reasonable ef-
10 fort to collect appropriate reimbursement for serv-
11 ices provided; and

12 (6) the applicant agrees to supplement and not
13 supplant the level of State or local funds under the
14 direct control of the applying State or participating
15 local education or health authority expended for
16 school health services as defined by this Act;

17 (7) services funded under this Act will be co-
18 ordinated with existing school health services pro-
19 vided at a participating school; and

20 (8) for applicants in rural areas, the assurances
21 required under paragraph (4) shall be fulfilled to the
22 maximum extent possible.

23 (e) STATE LAWS.—Notwithstanding any other provi-
24 sion in this part, no school based health clinic may provide
25 services, to any minor, when to do so is a violation of State

1 laws or regulations pertaining to informed consent for
2 medical services to minors.

3 (f) LIMITATION ON ADMINISTRATIVE FUNDS.—In
4 the case of a State applying on behalf of local educational
5 partnerships, the applicant may retain not more than 5
6 percent of grants awarded under this subpart for adminis-
7 trative costs.

8 (g) DURATION OF GRANT.—A grant under this sec-
9 tion shall be for a period determined appropriate by the
10 Secretary.

11 (h) AMOUNT OF GRANT.—The annual amount of a
12 grant awarded under this section shall not be more than
13 \$200,000 per school-based or school-linked health service
14 site.

15 (i) FEDERAL SHARE.—

16 (1) IN GENERAL.—Subject to paragraph (3), a
17 grant for services awarded under this section may
18 not exceed—

19 (A) 90 percent of the non-reimbursed cost
20 of the activities to be funded under the program
21 for the first 2 fiscal years for which the pro-
22 gram receives assistance under this section; and

23 (B) 75 percent of the non-reimbursed cost
24 of such activities for subsequent years for which

1 the program receives assistance under this sec-
2 tion.

3 The remainder of such costs shall be made available as
4 provided in paragraph (2).

5 (2) FORM OF NON-FEDERAL SHARE.—The non-
6 Federal share required by paragraph (1) may be in
7 cash or in-kind, fairly evaluated, including facilities,
8 equipment, personnel, or services, but may not in-
9 clude amounts provided by the Federal Government.
10 In-kind contributions may include space within a
11 school facilities, school personnel, program use of
12 school transportation systems, outposted health per-
13 sonnel, and extension of health provider medical li-
14 ability insurance.

15 (3) WAIVER.—The Secretary may waive the re-
16 quirements of paragraph (1) for any year in accord-
17 ance with criteria established by regulation. Such
18 criteria shall include a documented need for the
19 services provided under this section and an inability
20 of the grantee to meet the requirements of para-
21 graph (1) despite a good faith effort.

22 (j) TRAINING AND TECHNICAL ASSISTANCE.—Enti-
23 ties that receive assistance under this section may use not
24 to exceed 10 percent of the amount of such assistance to
25 provide staff training and to secure necessary technical as-

1 sistance. To the maximum extent feasible, technical assist-
 2 ance should be sought through local community-based en-
 3 tities. The limitation contained in this subsection shall
 4 apply to individuals employed to assist in obtaining funds
 5 under this part. Staff training should include the training
 6 of teachers and other school personnel necessary to ensure
 7 appropriate referral and utilization of services, and appro-
 8 priate linkages between class-room activities and services
 9 offered.

10 (k) REPORT AND MONITORING.—The Secretary will
 11 submit to the Committee on Labor and Human Resources
 12 in the Senate and the Committee on Energy and Com-
 13 merce in the House of Representatives a biennial report
 14 on the activities funded under this Act, consistent with
 15 the ongoing monitoring activities of the Department. Such
 16 reports are intended to advise the relevant Committees of
 17 the availability and utilization of services, and other rel-
 18 evant information about program activities.

19 **Subtitle F—Public Health Service** 20 **Initiative**

21 **SEC. 3601. PUBLIC HEALTH SERVICE INITIATIVE.**

22 (a) IN GENERAL.—Subject to subsection (c), the Sec-
 23 retary of Health and Human Services shall pay, from
 24 funds in the Treasury not otherwise appropriated, individ-
 25 uals and entities that are eligible to receive assistance pur-

1 suant to the provisions referred to in paragraphs (1)
2 through (8) of subsection (b), to the extent of the amounts
3 specified under subsection (b).

4 (b) AMOUNTS SPECIFIED.—The amounts specified in
5 subsection (a) with respect to a fiscal year shall be—

6 (1) with respect to the health services research
7 activities authorized under the amendments made by
8 section 3102, \$150,000,000 for fiscal year 1996,
9 \$400,000,000 for fiscal year 1997, \$500,000,000 for
10 fiscal year 1998, and \$600,000,000 for each of the
11 fiscal years 1999 through 2001;

12 (2) with respect to activities for the develop-
13 ment of plans and networks under subpart B of part
14 1 of subtitle C of title III—

15 (A) \$52,500,000 for fiscal year 1996,
16 \$122,500,000 for fiscal year 1997,
17 \$192,500,000 for fiscal year 1998,
18 \$157,500,000 for fiscal year 1999,
19 \$122,500,000 for fiscal year 2000, and
20 \$52,500,000 for fiscal year 2001; and

21 (B) with respect to awards to federally
22 qualified health centers (as defined in section
23 1861(aa)(4) of the Social Security Act) under
24 such subpart, \$97,500,000 for fiscal year 1996,
25 \$227,500,000 for fiscal year 1997,

1 \$357,500,000 for fiscal year 1998,
2 \$292,500,000 for fiscal year 1999,
3 \$227,500,000 for fiscal year 2000, and
4 \$97,500,000 for fiscal year 2001;

5 (3) with respect to capital costs under subpart
6 C of part 1 of subtitle C of title III, \$50,000,000
7 for each of the fiscal years 1996 through 2001;

8 (4) with respect to enabling services under sub-
9 part D of part 1 of subtitle C of title III—

10 (A) \$35,000,000 for fiscal year 1997,
11 \$140,000,000 for each of the fiscal years 1998
12 through 2000, and \$175,000,000 for fiscal year
13 2001; and

14 (B) with respect to awards to federally
15 qualified health centers (as defined in section
16 1861(aa)(4) of the Social Security Act) under
17 such subpart, \$65,000,000 for fiscal year 1997,
18 \$260,000,000 for each of the fiscal years 1998
19 through 2000, and \$325,000,000 for fiscal year
20 2001;

21 (5) with respect to supplemental services under
22 subpart D of part 1 of subtitle C of title III,
23 \$100,000,000 for fiscal year 1996, \$150,000,000 for
24 fiscal year 1997, and \$250,000,000 for each of the
25 fiscal years 1998 through 2001;

1 (6) with respect to the National Health Service
2 Corps program referred to under section 3371,
3 \$150,000,000 for each of the fiscal years 1997 and
4 1998, and \$250,000,000 for each of the fiscal years
5 1999 through 2001;

6 (7) with respect to the development and oper-
7 ation of comprehensive managed mental health and
8 substance abuse programs under section 3434,
9 \$100,000,000 for each of the fiscal years 1996
10 through 2001; and

11 (8) with respect to school-related health service
12 programs under subpart A of part 5 of subtitle E
13 of title III, \$100,000,000 for fiscal year 1996,
14 \$200,000,000 for fiscal year 1997, \$325,000,000 for
15 fiscal year 1998, and \$450,000,000 for fiscal year
16 1999, \$575,000,000 for fiscal year 2000, and
17 \$700,000,000 for fiscal year 2001.

18 (c) AUTHORITY TO TRANSFER FUNDS.—The Com-
19 mittee on Appropriations of the House of Representatives
20 and the Committee on Appropriations of the Senate, act-
21 ing through appropriations Acts, may transfer the
22 amounts specified under subsection (b) in each fiscal year
23 among the programs referred to in such subsection.

1 **TITLE IV—MEDICAL**
2 **MALPRACTICE**
3 **Subtitle A—Liability Reform**

4 **SEC. 4001. FEDERAL TORT REFORM.**

5 (a) APPLICABILITY.—

6 (1) IN GENERAL.—Except as provided in sec-
7 tion 4002, this subtitle shall apply with respect to
8 any medical malpractice liability action brought in
9 any State or Federal court, except that this subtitle
10 shall not apply to a claim or action for damages
11 arising from a vaccine-related injury or death to the
12 extent that title XXI of the Public Health Service
13 Act applies to the claim or action.

14 (2) EFFECT ON SOVEREIGN IMMUNITY AND
15 CHOICE OF LAW OR VENUE.—Nothing in this sub-
16 title shall be construed to—

17 (A) waive or affect any defense of sov-
18 ereign immunity asserted by any State under
19 any provision of law;

20 (B) waive or affect any defense of sov-
21 ereign immunity asserted by the United States;

22 (C) affect the applicability of any provision
23 of the Foreign Sovereign Immunities Act of
24 1976;

1 (D) preempt State choice-of-law rules with
2 respect to claims brought by a foreign nation or
3 a citizen of a foreign nation; or

4 (E) affect the right of any court to trans-
5 fer venue or to apply the law of a foreign nation
6 or to dismiss a claim of a foreign nation or of
7 a citizen of a foreign nation on the ground of
8 inconvenient forum.

9 (3) FEDERAL COURT JURISDICTION NOT ES-
10 TABLISHED ON FEDERAL QUESTION GROUNDS.—
11 Nothing in this subtitle shall be construed to estab-
12 lish any jurisdiction in the district courts of the
13 United States over medical malpractice liability ac-
14 tions on the basis of section 1331 or 1337 of title
15 28, United States Code.

16 (b) DEFINITIONS.—In this subtitle, the following
17 definitions apply:

18 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-
19 TEM; ADR.—The term “alternative dispute resolu-
20 tion system” or “ADR” means a system that pro-
21 vides for the resolution of medical malpractice claims
22 in a manner other than through medical malpractice
23 liability actions.

24 (2) CLAIMANT.—The term “claimant” means
25 any person who alleges a medical malpractice claim,

1 and any person on whose behalf such a claim is al-
2 leged, including the decedent in the case of an action
3 brought through or on behalf of an estate.

4 (3) HEALTH CARE PROFESSIONAL.—The term
5 “health care professional” means any individual who
6 provides health care services in a State and who is
7 required by the laws or regulations of the State to
8 be licensed or certified by the State to provide such
9 services in the State.

10 (4) HEALTH CARE PROVIDER.—The term
11 “health care provider” means any organization or
12 institution that is engaged in the delivery of health
13 care services in a State and that is required by the
14 laws or regulations of the State to be licensed or cer-
15 tified by the State to engage in the delivery of such
16 services in the State.

17 (5) INJURY.—The term “injury” means any ill-
18 ness, disease, or other harm that is the subject of
19 a medical malpractice liability action or a medical
20 malpractice claim.

21 (6) MEDICAL MALPRACTICE LIABILITY AC-
22 TION.—The term “medical malpractice liability ac-
23 tion” means a cause of action brought in a State or
24 Federal court against a health care provider or

1 health care professional by which the plaintiff alleges
2 a medical malpractice claim.

3 (7) MEDICAL MALPRACTICE CLAIM.—The term
4 “medical malpractice claim” means a claim brought
5 against a health care provider or health care profes-
6 sional in which a claimant alleges that injury was
7 caused by the provision of (or the failure to provide)
8 health care services, except that such term does not
9 include—

10 (A) any claim based on an allegation of an
11 intentional tort; or

12 (B) any claim based on an allegation that
13 a product is defective that is brought against
14 any individual or entity that is not a health
15 care professional or health care provider.

16 **SEC. 4002. STATE-BASED ALTERNATIVE DISPUTE RESOLU-**
17 **TION MECHANISMS.**

18 (a) APPLICATION TO MALPRACTICE CLAIMS UNDER
19 PLANS.—Prior to or immediately following the commence-
20 ment of any medical malpractice action, the parties shall
21 participate in the alternative dispute resolution system ad-
22 ministered by the State under subsection (b). Such partici-
23 pation shall be in lieu of any other provision of Federal
24 or State law or any contractual agreement made by or on

1 behalf of the parties prior to the commencement of the
2 medical malpractice action.

3 (b) ADOPTION OF MECHANISM BY STATE.—Each
4 State shall—

5 (1) maintain or adopt at least one of the alter-
6 native dispute resolution methods satisfying the re-
7 quirements specified under subsection (c) and (d) for
8 the resolution of medical malpractice claims arising
9 from the provision of (or failure to provide) health
10 care services to individuals enrolled in a health plan;
11 and

12 (2) clearly disclose to enrollees (and potential
13 enrollees) the availability and procedures for
14 consumer grievances, including a description of the
15 alternative dispute resolution method or methods
16 adopted under this subsection.

17 (c) SPECIFICATION OF PERMISSIBLE ALTERNATIVE
18 DISPUTE RESOLUTION METHODS.—

19 (1) IN GENERAL.—The Board shall, by regula-
20 tion, develop alternative dispute resolution methods
21 for the use by States in resolving medical mal-
22 practice claims under subsection (a). Such methods
23 shall include at least the following:

24 (A) ARBITRATION.—The use of arbitra-
25 tion, a nonjury adversarial dispute resolution

1 process which may, subject to subsection (d),
2 result in a final decision as to facts, law, liabil-
3 ity or damages.

4 (B) CLAIMANT-REQUESTED BINDING ARBI-
5 TRATION.—For claims involving a sum of
6 money that falls below a threshold amount set
7 by the Board, the use of arbitration not subject
8 to subsection (d). Such binding arbitration shall
9 be at the sole discretion of the claimant.

10 (C) MEDIATION.—The use of mediation, a
11 settlement process coordinated by a neutral
12 third party without the ultimate rendering of a
13 formal opinion as to factual or legal findings.

14 (D) EARLY NEUTRAL EVALUATION.—The
15 use of early neutral evaluation, in which the
16 parties make a presentation to a neutral attor-
17 ney or other neutral evaluator for an assess-
18 ment of the merits, to encourage settlement. If
19 the parties do not settle as a result of assess-
20 ment and proceed to trial, the neutral eval-
21 uator's opinion shall be kept confidential.

22 (E) CERTIFICATE OF MERIT.—The re-
23 quirement that a medical malpractice plaintiff
24 submit to the court before trial a written report
25 by a qualified specialist that includes the spe-

1 cialist's determination that, after a review of
2 the available medical record and other relevant
3 material, there is a reasonable and meritorious
4 cause for the filing of the action against the de-
5 fendant.

6 (2) STANDARDS FOR ESTABLISHING METH-
7 ODS.—In developing alternative dispute resolution
8 methods under paragraph (1), the Board shall as-
9 sure that the methods promote the resolution of
10 medical malpractice claims in a manner that—

11 (A) is affordable for the parties involved;

12 (B) provides for timely resolution of
13 claims;

14 (C) provides for the consistent and fair
15 resolution of claims; and

16 (D) provides for reasonably convenient ac-
17 cess to dispute resolution for individuals en-
18 rolled in plans.

19 (3) WAIVER AUTHORITY.—Upon application of
20 a State, the Board may grant the State the author-
21 ity to fulfill the requirement of subsection (b) by
22 adopting a mechanism other than a mechanism es-
23 tablished by the Board pursuant to this subsection,
24 except that such mechanism must meet the stand-
25 ards set forth in paragraph (2).

1 (d) FURTHER REDRESS.—Except with respect to the
2 claimant-requested binding arbitration method set forth in
3 subsection (c)(1)(B), and notwithstanding any other provi-
4 sion of a law or contractual agreement, a plan enrollee
5 dissatisfied with the determination reached as a result of
6 an alternative dispute resolution method applied under
7 this section may, after the final resolution of the enrollee’s
8 claim under the method, bring a cause of action to seek
9 damages or other redress with respect to the claim to the
10 extent otherwise permitted under State law. The results
11 of any alternative dispute resolution procedure are inad-
12 missible at any subsequent trial, as are all statements, of-
13 fers, and other communications made during such proce-
14 dures, unless otherwise admissible under State law.

15 **SEC. 4003. LIMITATION ON AMOUNT OF ATTORNEY’S CON-**
16 **TINGENCY FEES.**

17 (a) IN GENERAL.—An attorney who represents, on
18 a contingency fee basis, a plaintiff in a medical mal-
19 practice liability action may not charge, demand, receive,
20 or collect for services rendered in connection with such ac-
21 tion (including the resolution of the claim that is the sub-
22 ject of the action under any alternative dispute resolution
23 system) in excess of—

1 (1) $33\frac{1}{3}$ percent of the first \$150,000 of the
2 total amount recovered by judgment or settlement in
3 such action; plus

4 (2) 25 percent of any amount recovered above
5 the amount described in paragraph (1);

6 unless otherwise determined under State law. Such
7 amount shall be computed after deductions are made for
8 all the expenses associated with the claim other than those
9 attributable to the normal operating expenses of the attor-
10 ney.

11 (b) CALCULATION OF PERIODIC PAYMENTS.—In the
12 event that a judgment or settlement includes periodic or
13 future payments of damages, the amount recovered for
14 purposes of computing the limitation on the contingency
15 fee under subsection (a) may, in the discretion of the
16 court, be based on the cost of the annuity or trust estab-
17 lished to make the payments. In any case in which an an-
18 nuity or trust is not established to make such payments,
19 such amount shall be based on the present value of the
20 payments.

21 (c) CONTINGENCY FEE DEFINED.—As used in this
22 section, the term “contingency fee” means any fee for pro-
23 fessional legal services which is, in whole or in part, con-
24 tingent upon the recovery of any amount of damages,
25 whether through judgment or settlement.

1 **SEC. 4004. REDUCTION OF AWARDS FOR RECOVERY FROM**
2 **COLLATERAL SOURCES.**

3 (a) REDUCTION OF AWARD.—The total amount of
4 damages recovered by a plaintiff in a medical malpractice
5 liability action shall be reduced by an amount that
6 equals—

7 (1) the amount of any payment which the plain-
8 tiff has received or to which the plaintiff is presently
9 entitled on account of the same injury for which the
10 damages are awarded, including payment under—

11 (A) Federal or State disability or sickness
12 programs;

13 (B) Federal, State, or private health insur-
14 ance programs;

15 (C) private disability insurance programs;

16 (D) employer wage continuation programs;
17 and

18 (E) any other program, if the payment is
19 intended to compensate the plaintiff for the
20 same injury for which damages are awarded;
21 less

22 (2) the amount of any premiums or any other
23 payments that the plaintiff has paid to be eligible to
24 receive the payment described in paragraph (1) and
25 any portion of the award subject to a subrogation
26 lien or claim.

1 (b) SUBROGATION.—The court may reduce a sub-
2 rogation lien or claim described in subsection (a)(2) by
3 an amount representing reasonable costs incurred in se-
4 curing the award subject to the lien or claim.

5 (c) INAPPLICABILITY OF SECTION.—This section
6 shall not apply to any case in which the court determines
7 that the reduction of damages pursuant to subsection (a)
8 would compound the effect of any State law limitation on
9 damages so as to render the plaintiff less than fully com-
10 pensated for his or her injuries.

11 **SEC. 4005. PERIODIC PAYMENT OF AWARDS.**

12 (a) IN GENERAL.—A party to a medical malpractice
13 liability action may petition the court to instruct the trier
14 of fact to award any future damages on an appropriate
15 periodic basis. If the court, in its discretion, so instructs
16 the trier of fact, and damages are awarded on a periodic
17 basis, the court may require the defendant to purchase
18 an annuity or other security instrument (typically based
19 on future damages discounted to present value) adequate
20 to assure payments of future damages.

21 (b) FAILURE OR INABILITY TO PAY.—With respect
22 to an award of damages described in subsection (a), if a
23 defendant fails to make payments in a timely fashion, or
24 if the defendant becomes or is at risk of becoming insol-
25 vent, upon such a showing the claimant may petition the

1 court for an order requiring that remaining balance be dis-
 2 counted to present value and paid to the claimant in a
 3 lump-sum.

4 (c) MODIFICATION OF PAYMENT SCHEDULE.—The
 5 court shall retain authority to modify the payment sched-
 6 ule based on changed circumstances.

7 (d) FUTURE DAMAGES DEFINED.—As used in this
 8 section, the term “future damages” means any economic
 9 or noneconomic loss other than that incurred or accrued
 10 as of the time of judgment.

11 **SEC. 4006. CONSTRUCTION.**

12 Nothing in this subtitle shall be construed to preempt
 13 any State law that sets a maximum limit on total dam-
 14 ages.

15 **Subtitle B—Other Provisions Relat-**
 16 **ing to Medical Malpractice Li-**
 17 **ability**

18 **SEC. 4101. STATE MALPRACTICE REFORM DEMONSTRATION**
 19 **PROJECTS.**

20 (a) ESTABLISHMENT.—The Secretary shall award
 21 grants to States for the establishment of malpractice re-
 22 form demonstration projects in accordance with this sec-
 23 tion. Each such project shall be designed to assess the
 24 fairness and effectiveness of one or more of the following
 25 models:

1 (1) No-fault liability.

2 (2) Enterprise liability.

3 (3) Practice guidelines.

4 (b) DEFINITIONS.—For purposes of this section:

5 (1) MEDICAL ADVERSE EVENT.—The term
6 “medical adverse event” means an injury that is the
7 result of medical management as opposed to a dis-
8 ease process that creates disability lasting at least
9 one month after discharge, or that prolongs a hos-
10 pitalization for more than one month, and for which
11 compensation is available under a no-fault medical
12 liability system established under this section.

13 (2) NO-FAULT MEDICAL LIABILITY SYSTEM.—
14 The terms “no-fault medical liability system” and
15 “system” mean a system established by a State re-
16 ceiving a grant under this section which replaces the
17 common law tort liability system for medical injuries
18 with respect to certain qualified health care organi-
19 zations and qualified insurers and which meets the
20 requirements of this section.

21 (3) PROVIDER.—The term “provider” means
22 physician, physician assistant, or other individual
23 furnishing health care services in affiliation with a
24 qualified health care organization.

1 (4) QUALIFIED HEALTH CARE ORGANIZA-
2 TION.—The term “qualified health care organiza-
3 tion” means a hospital, a hospital system, a man-
4 aged care network, or other entity determined appro-
5 priate by the Secretary which elects in a State re-
6 ceiving a grant under this section to participate in
7 a no-fault medical liability system and which meets
8 the requirements of this section.

9 (5) QUALIFIED INSURER.—The term “qualified
10 insurer” means a health care malpractice insurer,
11 including a self-insured qualified health care organi-
12 zation, which elects in a State receiving a grant
13 under this section to participate in a no-fault medi-
14 cal liability system and which meets the require-
15 ments of this section.

16 (6) ENTERPRISE LIABILITY.—The term “enter-
17 prise liability” means a system in which State law
18 imposes malpractice liability on the health plan in
19 which a physician participates in place of personal li-
20 ability on the physician in order to achieve improved
21 quality of care, reductions in defensive medical prac-
22 tices, and better risk management.

23 (7) PRACTICE GUIDELINES.—The term “prac-
24 tice guidelines” means guidelines established by the

1 Agency for Health Care Policy and Research pursu-
2 ant to the Public Health Service Act or this Act.

3 (c) APPLICATIONS BY STATES.—

4 (1) IN GENERAL.—Each State desiring to es-
5 tablish a malpractice reform demonstration project
6 shall submit an application to the Secretary at such
7 time and in such manner as the Secretary shall re-
8 quire.

9 (2) CONTENTS OF APPLICATION.—An applica-
10 tion under paragraph (1) shall include—

11 (A) an identification of the State agency or
12 agencies that will administer the demonstration
13 project and be the grant recipient of funds for
14 the State;

15 (B) a description of the manner in which
16 funds granted to a State will be expended and
17 a description of fiscal control, accounting, and
18 audit procedures to ensure the proper dispersal
19 of and accounting for funds received under this
20 section; and

21 (C) such other information as the Sec-
22 retary determines appropriate.

23 (3) CONSIDERATION OF APPLICATIONS.—In re-
24 viewing all applications received from States desiring

1 to establish malpractice demonstration projects
2 under paragraph (1), the Secretary shall consider—

3 (A) data regarding medical malpractice
4 and malpractice litigation patterns in each
5 State;

6 (B) the contributions that any demonstra-
7 tion project will make toward reducing mal-
8 practice and costs associated with health care
9 injuries;

10 (C) diversity among the populations serv-
11 iced by the systems;

12 (D) geographic distribution; and

13 (E) such other criteria as the Secretary de-
14 termines appropriate.

15 (d) EVALUATION AND REPORTS.—

16 (1) BY THE STATES.—Each State receiving a
17 grant under this section shall conduct on-going eval-
18 uations of the effectiveness of any demonstration
19 project established in such State and shall submit an
20 annual report to the Secretary concerning the re-
21 sults of such evaluations at such times and in such
22 manner as the Secretary shall require.

23 (2) BY THE SECRETARY.—The Secretary shall
24 submit an annual report to Congress concerning the
25 fairness and effectiveness of the demonstration

1 projects conducted under this section. Such report
2 shall analyze the reports received by the Secretary
3 under paragraph (1).

4 (e) FUNDING.—

5 (1) IN GENERAL.—There are authorized to be
6 appropriated such sums as may be necessary to
7 carry out the purposes of this section.

8 (2) LIMITATIONS ON EXPENDITURES.—

9 (A) ADMINISTRATIVE EXPENSES.—Not
10 more than 10 percent of the amount of each
11 grant awarded to a State under this section
12 may be used for administrative expenses.

13 (B) WAIVER OF COST LIMITATIONS.—The
14 limitation under subparagraph (A) may be
15 waived as determined appropriate by the Sec-
16 retary.

17 (f) ELIGIBILITY FOR NO-FAULT DEMONSTRATION.—
18 A State is eligible to receive a no-fault liability demonstra-
19 tion grant if the application of the State under subsection
20 (c) includes—

21 (1) an identification of each qualified health
22 care organization selected by the State to participate
23 in the system, including—

24 (A) the location of each organization;

1 (B) the number of patients generally
2 served by each organization;

3 (C) the types of patients generally served
4 by each organization;

5 (D) an analysis of any characteristics of
6 each organization which makes such organiza-
7 tion appropriate for participation in the system;

8 (E) whether the organization is self-in-
9 sured for malpractice liability; and

10 (F) such other information as the Sec-
11 retary determines appropriate;

12 (2) an identification of each qualified insurer
13 selected by the State to participate in the system, in-
14 cluding—

15 (A) a schedule of the malpractice insur-
16 ance premiums generally charged by each in-
17 surer under the common law tort liability sys-
18 tem; and

19 (B) such other information as the Sec-
20 retary determines appropriate;

21 (3) a description of the procedure under which
22 qualified health care organizations and insurers elect
23 to participate in the system;

24 (4) a description of the system established by
25 the State to assure compliance with the require-

1 ments of this section by each qualified health care
2 organization and insurer; and

3 (5) a description of procedures for the prepara-
4 tion and submission to the State of an annual report
5 by each qualified health care organization and quali-
6 fied insurer participating in a system that shall in-
7 clude—

8 (A) a description of activities conducted
9 under the system during the year; and

10 (B) the extent to which the system ex-
11 ceeded or failed to meet relevant performance
12 standards including compensation for and de-
13 terrence of medical adverse events.

14 (g) ELIGIBILITY FOR ENTERPRISE LIABILITY DEM-
15 ONSTRATION.—A State is eligible to receive an enterprise
16 liability demonstration grant if the State—

17 (1) has entered into an agreement with a health
18 plan (other than a fee-for-service plan) operating in
19 the State under which the plan assumes legal liabil-
20 ity with respect to any medical malpractice claim
21 arising from the provision of (or failure to provide)
22 services under the plan by any physician participat-
23 ing in the plan; and

24 (2) has provided that, under the law of the
25 State, a physician participating in a plan that has

1 entered into an agreement with the State under
 2 paragraph (1) may not be liable in damages or oth-
 3 erwise for such a claim and the plan may not require
 4 such physician to indemnify the plan for any such li-
 5 ability.

6 (h) ELIGIBILITY FOR PRACTICE GUIDELINES DEM-
 7 ONSTRATION.—A State is eligible to receive a practice
 8 guidelines demonstration grant if the law of the State pro-
 9 vides that in the resolution of any medical malpractice ac-
 10 tion, compliance or non-compliance with an appropriate
 11 practice guideline shall be admissible at trial as a rebutta-
 12 ble presumption regarding medical negligence.

13 **TITLE V—FALL-BACK PREMIUM**
 14 **LIMITS IN CASES OF INEFFECTIVE**
 15 **COMPETITION; PREMIUM-BASED FINANCING; AS-**
 16 **SISTANCE TO LOW INCOME**
 17 **INDIVIDUALS AND TO BUSI-**
 18 **NESSES**

20 **SEC. 5000. GENERAL DEFINITIONS.**

21 (a) DEFINITIONS RELATING TO PREMIUM RATES.—
 22 In this title:

23 (1) FILED COMMUNITY BID.—The term “filed
 24 community bid” means the premium bid that is filed
 25 with a State for a class of enrollment for a commu-

1 nity-rated plan offered in a community rating area
 2 pursuant to section 1413(b).

3 (2) ACCEPTED COOPERATIVE BID.—The term
 4 “accepted cooperative bid” means the premium rate
 5 agreed upon by a cooperative and a plan taking into
 6 account any discount to such bid.

7 (3) FINAL COMMUNITY RATE.—The term “final
 8 community rate” means the filed community bid,
 9 taking into account any voluntary reduction in such
 10 bid made under section 5004(e).

11 (4) FINAL COOPERATIVE RATE.—The term
 12 “final cooperative bid” means the accepted coopera-
 13 tive bid, taking into account any voluntary reduc-
 14 tions in such bid made under section 5004(e).

15 (b) DEFINITIONS RELATED TO WEIGHTED AVERAGE
 16 PREMIUM RATES.—In this title:

17 (1) WEIGHTED AVERAGE ACCEPTED BID.—The
 18 term “weighted average accepted bid” means, for a
 19 class of enrollment for a community rating area for
 20 a year, the average across all plans of—

21 (A) the filed community bid for such class
 22 for each community-rated health plan offered in
 23 a community rating area weighted to reflect the
 24 relative enrollment (net of any enrollment

1 through a cooperative) of community rate eligi-
2 ble individuals among such plans; and

3 (B) the accepted cooperative bid for such
4 class for each community-rated health plan of-
5 fered in a community rating area weighted to
6 reflect the relative enrollment of community
7 rate eligible individuals through a cooperative
8 among such plans.

9 (2) WEIGHTED AVERAGE PREMIUM.—The term
10 “weighted average premium” means, for a class of
11 enrollment for a community rating area for a year,
12 the lesser of—

13 (A) the baseline premium for such class for
14 the community rating area (as defined in sec-
15 tion 5003) for the year; or

16 (B) the average across all plans of the less-
17 er of—

18 (i) the final community rate; or

19 (ii) the final cooperative rate, for such
20 class (applicable only for plans offered
21 through the cooperative);

22 for each community-rated health plan, weighted
23 to reflect the total enrollment of community
24 rate eligible individuals in such class among
25 such plans.

1 (d) INCORPORATION OF OTHER DEFINITIONS.—Ex-
 2 cept as otherwise provided in this title, the definitions of
 3 terms in subtitle H of title I of this Act shall apply to
 4 this title.

5 **Subtitle A—Fall-Back Premium**
 6 **Limits**

7 **PART 1—HEALTH EXPENDITURES OF**
 8 **COMMUNITY RATING AREAS**

9 **Subpart A—Computation of Targets and Accepted**
 10 **Bids**

11 **SEC. 5001. COMPUTATION OF AREA INFLATION FACTORS.**

12 (a) COMPUTATION.—

13 (1) IN GENERAL.—The Secretary shall compute
 14 and publish, not later than March 1 of each year
 15 (beginning with 1996) the area inflation factor (as
 16 defined in paragraph (2)) for each community rating
 17 area for the following year.

18 (2) COMMUNITY RATING AREAS INFLATION
 19 FACTOR.—The term “area inflation factor” means,
 20 for a year for a community rating area—

21 (A) the general health care inflation factor
 22 for the year (as defined in paragraph (3));

23 (B) adjusted under subsection (c) (to take
 24 into account material changes in the demo-
 25 graphic and socio-economic characteristics of

1 the population of community rate eligible indi-
2 viduals); and

3 (C) decreased by the percentage adjust-
4 ment (if any) provided with respect to the com-
5 munity rating area under subsection (d) (relat-
6 ing to adjustment for previous excess expendi-
7 tures).

8 (3) GENERAL HEALTH CARE INFLATION FAC-
9 TOR.—

10 (A) 1997 THROUGH 2001.—In this part,
11 the term “general health care inflation factor”,
12 for a year, means the percentage increase in the
13 CPI (as specified under subsection (b)) for the
14 year plus the following:

15 (i) For 1997, 1.5 percentage points.

16 (ii) For 1998, 1.0 percentage points.

17 (iii) For 1999, 0.5 percentage points.

18 (iv) For 2000 and for 2001, 0 per-
19 centage points.

20 (B) YEARS AFTER 2001.—

21 (i) RECOMMENDATION TO CON-
22 GRESS.—In 2000, the Secretary shall sub-
23 mit to Congress recommendations, after
24 consultation with the Federal Reserve
25 Board, on what the general health care in-

1 flation factor should be for years beginning
2 with 2002.

3 (ii) FAILURE OF CONGRESS TO ACT.—

4 If the Congress fails to enact a law specify-
5 ing the general health care inflation factor
6 for a year after 2001, the Secretary, in
7 January of the year before the year in-
8 volved, shall compute such factor for the
9 year involved. Such factor shall be the
10 product of the factors described in sub-
11 paragraph (C) for that fiscal year, minus
12 1.

13 (C) FACTORS.—The factors described in
14 this subparagraph for a year are the following:

15 (i) CPI.—1 plus the percentage
16 change in the CPI for the year, determined
17 based upon the percentage change in the
18 average of the CPI for the 12-month pe-
19 riod ending with August 31 of the previous
20 fiscal year over such average for the pre-
21 ceding 12-month period.

22 (ii) REAL GDP PER CAPITA.—1 plus
23 the average annual percentage change in
24 the real, per capita gross domestic product
25 of the United States during the 3-year pe-

1 riod ending in the preceding calendar year,
2 determined by the Secretary based on data
3 supplied by the Department of Commerce.

4 (b) PROJECTION OF INCREASE IN CPI.—

5 (1) IN GENERAL.—For purposes of this section,
6 the Secretary shall specify, as of the time of publica-
7 tion, the annual percentage increase in the CPI (as
8 defined in section 1701(d)) for the following year.

9 (2) DATA TO BE USED.—Such increase shall be
10 the projection of the CPI contained in the budget of
11 the United States transmitted by the President to
12 the Congress in the year.

13 (c) SPECIAL ADJUSTMENT FOR MATERIAL CHANGES
14 IN DEMOGRAPHIC CHARACTERISTICS OF POPULATION.—

15 (1) IN GENERAL.—The Secretary shall develop
16 a method for adjusting the area inflation factor for
17 each community rating area in order to reflect mate-
18 rial changes in the demographic characteristics of
19 community rate eligible individuals residing in the
20 coverage area in comparison to national trend for
21 factors that affect utilization of health care services.

22 (2) NEUTRAL ADJUSTMENT.—Such method
23 (and any annual adjustment under this paragraph)
24 shall be designed to result in the adjustment effected

1 under this paragraph for a year not changing the
2 weighted average of the area inflation factors.

3 (d) CONSULTATION PROCESS.—The Secretary shall
4 have a process for consulting with representatives of
5 States before establishing the area inflation factors for
6 each year under this section.

7 **SEC. 5002. ESTABLISHMENT OF BASELINE PREMIUMS.**

8 (a) IN GENERAL.—Not later than January 1, 1996,
9 the Secretary shall determine baseline premium amounts
10 applicable under this title. Such premiums shall be—

11 (1) the premium amount as of January 1, 1995
12 for employee-only coverage under Blue Cross/Blue
13 Shield standard option plan available through the
14 Federal Employees Health Benefits Program (in the
15 case of the individual class of enrollment); and

16 (2) such amounts as determined appropriate by
17 the Secretary after making the necessary adjust-
18 ments to the amount described in (1) to reflect the
19 relative difference in actuarial value among the dif-
20 ferent classes of family enrollment (in the case of
21 the classes described in section 1413(b)(2)(B);

22 updated in accordance with sections (b), (c), and (d).

23 (b) ADJUSTMENT FOR ELIGIBLE POPULATION.—The
24 premium amounts described in paragraphs (1) and (2) of
25 subsection (a) shall be adjusted to reflect the difference

1 in expected health care spending of the population enrolled
2 in the plan described in paragraph (1) of subsection (a)
3 and of the population of community rate eligible individ-
4 uals (exclusive of individuals receiving AFDC or SSI).

5 (c) REMOVAL OF UNCOMPENSATED CARE.—The pre-
6 mium amounts described in paragraphs (1) and (2) of
7 subsection (a) shall be reduced to remove assumed uncom-
8 pensated and undercompensated care that will be elimi-
9 nated by this Act.

10 (d) UPDATING.—

11 (1) IN GENERAL.—Subject to paragraph (3),
12 the Secretary shall update the amount determined
13 under subsection (b)(1) for each of 1995 and 1996
14 by the update factor described in paragraph (2) for
15 the year.

16 (2) UPDATE FACTOR.—In paragraph (1), the
17 update factor for a year is 1 plus the annual per-
18 centage increase for the year for the premium
19 charged for individual enrollment in Blue Cross/Blue
20 Shield standard option plan offered through the
21 Federal Employees Health Benefits Program.

22 (3) LIMIT.—The total cumulative update under
23 this subsection shall not exceed 15 percent.

1 **SEC. 5003. DETERMINATION OF AREA BASELINE PRE-**
2 **MIUMS.**

3 (a) INITIAL DETERMINATION.—Not later than Janu-
4 ary 1, 1996, the Secretary shall determine, for each com-
5 munity rating area for 1997, area baseline premiums. For
6 each class of enrollment, the baseline premium shall
7 equal—

8 (1) the national baseline premium for such class
9 (determined by the Secretary under section 5002),

10 (2) updated by the area inflation factor (as de-
11 termined under section 5001) for 1997, and

12 (3) adjusted by the adjustment factor for the
13 community rating area (determined under subsection
14 (c)).

15 (b) SUBSEQUENT DETERMINATIONS.—

16 (1) DETERMINATION.—Not later than March 1
17 of each year (beginning with 1997) the Secretary
18 shall determine, for each community rating area for
19 the succeeding year area baseline premiums.

20 (2) GENERAL RULE.—Subject to subsection (e),
21 such baseline premium shall equal—

22 (A) the area baseline premium determined
23 under this section (without regard to subsection
24 (e)) for the community rating area for the pre-
25 vious year,

1 (B) updated by the area inflation factor
2 (as determined in section 5001) for the year.

3 (3) ADJUSTMENT FOR PREVIOUS EXCESS RATE
4 OF INCREASE IN EXPENDITURES.—Such target for a
5 year is subject to a decrease under section 5003(e).

6 (c) ADJUSTMENT FACTORS FOR COMMUNITY RATING
7 AREAS FOR INITIAL DETERMINATION.—

8 (1) IN GENERAL.—The Secretary shall establish
9 an adjustment factor for each community rating
10 area.

11 (2) CONSIDERATIONS.—In establishing such
12 factor, the Secretary shall consider, the difference
13 between the national average and the community
14 rating area in such measures as health care expendi-
15 tures, rates of uninsurance and underinsurance, and
16 in the proportion of expenditures for services pro-
17 vided by academic health centers. The Secretary
18 shall also take into consideration—

19 (A) information on variations in the extent
20 to which States and community rating areas
21 need additional investment because they have
22 successfully controlled health care costs; and

23 (B) information on variations among
24 States and community rating areas due to un-
25 derutilization of health care services resulting

1 from geographic barriers and lack of access to
2 health care services, particularly in underserved
3 rural and urban areas.

4 (3) APPLICATION OF FACTORS IN NEUTRAL
5 MANNER.—The application of the adjustment factors
6 under this subsection for 1997 shall be done in a
7 manner so that the weighted average of the area
8 baseline premiums for a class of enrollment for 1997
9 is equal to the national baseline premium for such
10 class determined under section 5002. Such weighted
11 average shall be based on the Secretary's estimate of
12 the expected distribution of community rate eligible
13 individuals (taken into account under section 5002)
14 among the community rating areas.

15 (4) CONSULTATION PROCESS.—The Secretary
16 shall have a process for consulting with representa-
17 tives of States and purchasing cooperatives before
18 establishing the adjustment for community rating
19 areas under this subsection.

20 (d) TREATMENT OF CERTAIN STATES.—In the case
21 of a State that is not a participating State or otherwise
22 has not established community rating areas, the entire
23 State shall be treated under the provisions of this part
24 as composing a single community rating area.

1 (e) ADJUSTMENT FOR PREVIOUS EXCESS RATE OF
 2 INCREASE IN EXPENDITURES.—If the actual weighted av-
 3 erage premium for a community rating area for a class
 4 of enrollment for a year (as determined by the Secretary
 5 based on actual enrollment in the first month of the year)
 6 exceeds the area baseline premiums (determined under
 7 this section) for the year, then the area baseline premium
 8 shall be reduced, by $\frac{1}{2}$ of the excess for the year, for each
 9 of the 2 succeeding years.

10 **SEC. 5004. INITIAL RATE FILING AND BID NEGOTIATION**
 11 **PROCESS.**

12 (a) FILING AND BIDDING PROCESS.—

13 (1) FILING COMMUNITY BIDS.—

14 (A) IN GENERAL.—Each participating
 15 State shall establish rules and procedures for a
 16 plan seeking to participate as a community-
 17 rated health plan to file a premium rate with
 18 the State and submit a premium bid to co-
 19 operatives for coverage of the benefits as re-
 20 quired under section 1101.

21 (B) CONDITION.—Each community bid
 22 filed and cooperative bid submitted under this
 23 subsection with respect to a community-rated
 24 health plan shall be conditioned upon the plan's

1 agreement to accept any payment reduction
2 that may be imposed under section 5011.

3 (2) NEGOTIATION PROCESS.—Following the
4 bidding process under paragraph (1), a State or a
5 cooperative may conduct negotiations with health
6 plans relating to the premiums to be charged for
7 such community-rated health plans within a State or
8 cooperative. Such negotiations may result in the re-
9 submission of bids to the State or cooperative, but
10 in no case shall a health plan resubmit a bid that
11 exceeds its prior bid.

12 (3) LEGALLY BINDING BIDS.—All rates filed
13 and bids submitted under this subsection must be le-
14 gally binding with respect to the plans involved.

15 (4) ACCEPTANCE.—

16 (A) COMMUNITY BID.—The final commu-
17 nity rate for a community-rated health plan
18 under this subsection shall be considered to be
19 the accepted bid for such plan, except as pro-
20 vided in subsection (e).

21 (B) COOPERATIVE BID.—The final cooper-
22 ative bid submitted to a cooperative for a com-
23 munity-rated health plan under this subsection
24 shall be considered to be the accepted bid for
25 such plan, except as provided in subsection (e).

1 (5) ASSISTANCE.—The Secretary shall provide
2 States and cooperatives with such information and
3 technical assistance as may assist such States and
4 cooperatives in carrying out the provisions of this
5 subsection.

6 (b) SUBMISSION OF INFORMATION TO THE SEC-
7 RETARY.—By not later than September 1 of each year for
8 which community bids are filed under subsection (a), each
9 State shall submit to the Secretary such information as
10 the Secretary determines necessary to conduct the process
11 described in subsection (c).

12 (c) COMPUTATION OF WEIGHTED AVERAGE ACCEPT-
13 ED BID.—

14 (1) IN GENERAL.—For each community rating
15 area the Secretary shall determine a weighted aver-
16 age accepted bid for each class of enrollment for
17 each year for which rates are filed with the State
18 under subsection (a). Such determination shall be
19 based on information, submitted under subsection
20 (b).

21 (2) EXCLUSION OF WORKSITE HEALTH PRO-
22 MOTION DISCOUNTS.—For purposes of calculating
23 the weighted average accepted bid and enforcing
24 baseline premiums in a community rating area in a
25 State, the Secretary shall consider the accepted bids

1 for the year, without consideration or inclusion of
2 any worksite health promotion discount.

3 (d) NOTICE TO CERTAIN STATES.—

4 (1) IN GENERAL.—By not later than October 1
5 of each year for which rates are filed with a State,
6 the Secretary shall notify a State if the weighted av-
7 erage accepted bid for a class of enrollment (deter-
8 mined under subsection (c)) for the community rat-
9 ing area is greater than the area baseline premium
10 for such class for such area (determined under sec-
11 tion 5003) for the year.

12 (2) NOTICE OF PREMIUM REDUCTIONS.—If no-
13 tice is provided to a State under paragraph (1), the
14 Secretary shall notify the State and each noncomply-
15 ing plan of any plan payment reduction computed
16 under section 5011 for such a plan and the oppor-
17 tunity to voluntarily reduce the accepted bid under
18 subsection (e) in order to avoid such a reduction.

19 (e) VOLUNTARY REDUCTION OF ACCEPTED BIDS.—
20 After the Secretary has determined under subsection (c)
21 the weighted average accepted bid for a class of enrollment
22 for a community rating area and the Secretary has deter-
23 mined plan payment reductions, before such date as the
24 Secretary may specify (in order to provide for an open en-
25 rollment period), a noncomplying plan has the opportunity

1 to voluntarily reduce its filed community bid (and if appli-
2 cable, its accepted cooperative bid) for such class by the
3 amount of the plan payment reduction that would other-
4 wise apply to the plan. Such reduction shall not affect the
5 amount of the plan payment reduction for any other plan
6 for that year.

7 **SEC. 5005. STATE FINANCIAL INCENTIVES.**

8 (a) ELECTION.—Any participating State may elect to
9 assume responsibility for containment of health care ex-
10 penditures in the State consistent with the targets estab-
11 lished by this part upon the approval of an application
12 by the Secretary.

13 (b) ALTERNATIVE STATE PROVIDER PAYMENT SYS-
14 TEMS.—Notwithstanding any other provision of law, in the
15 case of an alternative State provider payment system that
16 has been approved by the Secretary and in continuous op-
17 eration since July 1, 1977, the payment rates and meth-
18 odologies required under the State system for services pro-
19 vided in that State shall apply to all purchasers and
20 payors, including those under employee welfare benefit
21 plans authorized under the Employee Retirement Income
22 Security Act of 1974, workers' compensation programs
23 under State law, the Federal Employees' Compensation
24 Act under chapter 81 of title 5, United States Code, and

1 Federal employee health benefit plans under chapter 89
2 of title 5, United States Code.

3 **Subpart B—Plan and Provider Payment Reductions**
4 **to Maintain Adequate Financing**

5 **SEC. 5011. PLAN PAYMENT REDUCTION.**

6 (a) PLAN PAYMENT REDUCTION.—In order to assure
7 that premium-related payments to community-rated
8 health plans offered in a community rating area are con-
9 sistent with the applicable area baseline premium for the
10 community rating area (computed under this subtitle), the
11 Secretary shall develop and utilize a methodology to re-
12 duce payments to each noncomplying plan within a non-
13 complying community rating area proportionate to the ex-
14 cess premium of each such plan and the relative share of
15 enrollment of community rate eligible individuals in each
16 such plan. Such methodology shall include mechanisms for
17 automatic reductions in payments made by noncomplying
18 plans to network and nonnetwork providers affiliated with
19 such plan. Such mechanism shall take into account in-
20 duced volume offsets.

21 (b) NONCOMPLYING COMMUNITY RATING AREA AND
22 NONCOMPLYING PLAN DEFINED.—In this part:

23 (1) NONCOMPLYING COMMUNITY RATING
24 AREA.—The term “noncomplying community rating
25 area” means, for a year, a community rating area

1 for which the weighted average accepted bid (com-
 2 puted under section 5004(c)) exceeds the community
 3 rating area baseline premium for the year.

4 (2) NONCOMPLYING PLAN.—The term “non-
 5 complying plan” means, for a year, a community
 6 rated health plan offered in a noncomplying commu-
 7 nity rating area if the applicable premium rate for
 8 a class of enrollment for the plan for the year ex-
 9 ceeds the baseline premiums for such class for the
 10 year.

11 (c) EXCESS PREMIUM.—In this section, the “excess
 12 premium”, with respect to a noncomplying plan for a year
 13 for a class of enrollment, is the amount by which—

14 (1) the accepted bid for the year for such class
 15 (taking into account any voluntary reduction under
 16 section 5004(e)), exceeds

17 (2) the baseline premium for such class (as de-
 18 fined in subsection (d)) for the plan for the year.

19 (d) COMMUNITY-RATED HEALTH PLANS WITH AN
 20 ACCEPTED COOPERATIVE BID NOT EQUAL TO THE FINAL
 21 COMMUNITY RATE FOR SUCH PLAN.—For the purposes
 22 of this section (relating to determining plan compliance
 23 and plan payment reduction), if a community-rated health
 24 plan has more than one applicable premium rate for a
 25 class of enrollment, such health plan shall be treated as

1 a separate health plan with respect to each applicable pre-
2 mium rate for such class and the enrollment in each such
3 health plan shall be considered to be the number of com-
4 munity-rated individuals enrolled in the community-rated
5 plan at the applicable premium rate.

6 **SEC. 5012. PROVIDER PAYMENT AGREEMENTS.**

7 (a) PARTICIPATING PROVIDERS.—Each community-
8 rated health plan in the community rating area, as part
9 of its contract or agreement with any participating pro-
10 vider or provider group of participating providers shall in-
11 clude a provision that provides that if the plan is a non-
12 complying plan for a year, payments to the provider (or
13 provider group) shall be reduced by an amount determined
14 appropriate by the Secretary under section 5011(a).

15 (b) APPLICATION TO COST SHARING AND TO BAL-
16 ANCE BILLING RESTRICTIONS.—For purposes of applying
17 section 1103 (relating to balance billing prohibitions) and
18 subtitle B of title I (relating to computation of cost shar-
19 ing), the payment basis otherwise used for computing any
20 limitation on billing or cost sharing shall be such payment
21 basis as adjusted by any reductions effected under this
22 section.

1 **PART 2—HEALTH EXPENDITURES OF LARGE**
2 **EMPLOYERS**

3 **SEC. 5021. CALCULATION OF PREMIUM EQUIVALENTS.**

4 (a) IN GENERAL.—By January 1, 1997, the Sec-
5 retary shall develop a methodology for calculating an an-
6 nual per capita expenditure equivalent for amounts paid
7 for coverage for the benefit package by a large employer.

8 (b) ADJUSTMENT PERMITTED.—Such methodology
9 shall permit a large employer to petition the Secretary of
10 Labor for an adjustment of the inflation adjustment that
11 would otherwise apply to compensate for material changes
12 in the demographic characteristics of the experience rate
13 eligible individuals receiving coverage through plans of-
14 fered by the employer in a community rating area.

15 (c) REPORTING.—

16 (1) IN GENERAL.—In 1999 and each subse-
17 quent year, each large employer offering a health
18 plan prior to 1999, shall report to the Secretary of
19 Labor, in a form and manner specified by the Sec-
20 retary, the average of the annual per capita expendi-
21 ture equivalent for the previous 3-year period.

22 (2) OTHER EMPLOYERS.—Each large employer
23 not previously offering a plan shall make such a re-
24 port in 2002 and in each subsequent year.

1 **SEC. 5022. SANCTIONS FOR LARGE EMPLOYER FOR EXCESS**
2 **INCREASE IN EXPENDITURES.**

3 (a) SANCTION.—

4 (1) ACTIONS AGAINST LARGE EMPLOYERS.—If
5 a large employer has two excess years (as defined in
6 subsection (b)) in a 3-year-period, then, effective be-
7 ginning with the second year following the second
8 excess year in such period, the Secretary of Labor
9 shall take action under section 1502, and such em-
10 ployer shall be considered to be a small employer for
11 purposes of this Act and shall be required to make
12 premium payments in accordance with section 5124.

13 (2) TERMINATION OF SPONSORSHIP FOR OTHER
14 EXPERIENCE-RATED PLANS.—If an association,
15 church, or multi-employer plan has two excess years
16 (as defined in subsection (b)) in a 3-year-period,
17 then, effective beginning with the second year follow-
18 ing the second excess year in such period—

19 (A) the Secretary of Labor shall terminate
20 the election of the large employer under section
21 1502; and

22 (B) an employer that was an experience-
23 rated employer with respect to such purchaser
24 shall become a community-rated employer (un-
25 less the employer is a large employer).

26 (b) EXCESS YEAR.—

1 (1) IN GENERAL.—In subsection (a), the term
2 “excess year” means, for a large employer referred
3 to in section 5021(c)(2), a year (after 2000) and for
4 an employer or plan referred to in section
5 5021(c)(1) or 5022(a)(2) a year (after 1998), for
6 which the rate of increase for the large employer
7 (specified in paragraph (2)) for the year, exceeds
8 the national corporate inflation factor (specified in
9 paragraph (3)) for the year.

10 (2) RATE OF INCREASE FOR LARGE EM-
11 PLOYER.—The rate of increase for a large employer
12 for a year, specified in this paragraph, is the per-
13 centage by which the average of the annual per cap-
14 ita expenditure equivalent for the large employer (re-
15 ported under section 5021 (c)) for the 3-year period
16 ending with such year, exceeds the average of the
17 annual per capita expenditure equivalent for the
18 large group purchaser (reported under such sub-
19 section) for the 3-year period ending with the pre-
20 vious year adjusted for any changes in the actuarial
21 value of the benefit package provided by such large
22 employer.

23 (3) NATIONAL CORPORATE INFLATION FAC-
24 TOR.—The national corporate inflation factor for a
25 year, specified in this paragraph, is the average of

1 the general health care inflation factors (as defined
 2 in section 5001(a)(3)) for each of the 3 years ending
 3 with such year.

4 **PART 3—TREATMENT OF SINGLE-PAYER STATES**

5 **SEC. 5031. SPECIAL RULES FOR SINGLE-PAYER STATES.**

6 In the case of a Statewide single-payer State, the Sec-
 7 retary shall compute a Statewide per capita premium tar-
 8 get for each year in the same manner as the community
 9 rating area per capita premium target is determined under
 10 section 5003.

11 **Subtitle B—Premium-Related**
 12 **Financings**

13 **PART 1—FAMILY PREMIUM PAYMENTS**

14 **Subpart A—Family Share**

15 **SEC. 5101. FAMILY SHARE OF PREMIUM.**

16 (a) REQUIREMENT.—Each family enrolled in a com-
 17 munity-rated health plan or in a, experienced-rated health
 18 plan in a class of family enrollment is responsible for pay-
 19 ment of the family share of premium payable respecting
 20 such enrollment. Such premium may be paid by an em-
 21 ployer or other person on behalf of such a family.

22 (b) FAMILY SHARE OF PREMIUM DEFINED.—

23 (1) IN GENERAL.—In this subtitle, the term
 24 “family share of premium” means, with respect to
 25 enrollment of a family—

1 (A) in a community-rated health plan, the
 2 amount specified in paragraph (2) for the class,
 3 or

4 (B) in an experienced-rated health plan,
 5 the amount specified in paragraph (3) for the
 6 class.

7 (2) COMMUNITY-RATED PLANS.—

8 (A) IN GENERAL.—The amount specified
 9 in this paragraph for a health plan based on a
 10 class of family enrollment is the base amount
 11 described in subparagraph (B) reduced (but not
 12 below zero) by the sum of the amounts de-
 13 scribed in subparagraph (C).

14 (B) BASE.—The base amounts described
 15 in this subparagraph (for a plan for a class of
 16 enrollment) is the applicable premium with re-
 17 spect to such class of enrollment.

18 (C) CREDITS AND DISCOUNTS.—The
 19 amounts described in this subparagraph (for a
 20 plan for a class of enrollment) are as follows:

21 (i) FAMILY CREDIT.—The amount of
 22 the family credit under section 5102(a).

23 (ii) INCOME RELATED DISCOUNT.—
 24 The amount of any income-related discount
 25 provided under section 5103.

1 (D) LIMIT ON MISCELLANEOUS CRED-
 2 ITS.—In no case shall the family share, due to
 3 credits under subparagraph (C), be less than
 4 zero.

5 (3) EXPERIENCE-RATED PLANS.—

6 (A) IN GENERAL.—The amount specified
 7 in this paragraph for an experience-rated health
 8 plan based on a class of family enrollment is
 9 the applicable premium (for a plan for a class
 10 of enrollment) reduced (but not below zero) by
 11 the sum of the amounts described in subpara-
 12 graph (B).

13 (B) CREDITS AND DISCOUNTS.—The
 14 amounts described in this subparagraph (for a
 15 plan for a class of enrollment) are as follows:

16 (i) FAMILY CREDIT.—The amount of
 17 the family credit under section 5102.

18 (ii) INCOME RELATED DISCOUNT.—
 19 The amount of any income-related discount
 20 provided under section 5103.

21 **SEC. 5102. FAMILY CREDIT.**

22 (a) COMMUNITY-RATED PLANS.—The credit pro-
 23 vided under this section for a family enrolled in a commu-
 24 nity-rated plan for a class of family enrollment is equal
 25 to 80 percent of the weighted average premium (as defined

1 in section 5000(b)) for community-rated plans offered in
 2 the community rating area for the class.

3 (b) EXPERIENCE-RATED PLANS.—The credit pro-
 4 vided under this section for a family enrolled in an experi-
 5 ence-rated health plan for a class of family enrollment is
 6 equal to the minimum employer premium payment re-
 7 quired under section 5131 with respect to the family.

8 **SEC. 5103. PREMIUM DISCOUNT BASED ON INCOME.**

9 (a) IN GENERAL.—

10 (1) ENROLLEES IN COMMUNITY-RATED
 11 PLANS.—Subject to paragraph (2), each family en-
 12 rolled with a community-rated or experience-rated
 13 plan is entitled to a premium discount under this
 14 section, in the amount specified in subsection (b)(1)
 15 if the family—

16 (A) is an AFDC or SSI family;

17 (B) is determined, under this title, to have
 18 family adjusted income below 150 percent of
 19 the applicable poverty level; or

20 (C) is a family described in subsection
 21 (c)(3) for which the family obligation amount
 22 under subsection (c) for the year would other-
 23 wise exceed a specified percent of family ad-
 24 justed income described in such subsection.

1 (2) MONTHLY APPLICATION TO AFDC AND SSI
2 FAMILIES.—Paragraph (1)(A) (and the family obli-
3 gation amount under subsection (c) insofar as it re-
4 lates to an AFDC or SSI family) shall be applied to
5 the premium or family obligation amount only for
6 months in which the family is such an AFDC or SSI
7 family.

8 (b) AMOUNT OF PREMIUM DISCOUNT.—

9 (1) IN GENERAL.—Subject to the succeeding
10 paragraphs of this subsection, the amount of the
11 premium discount under this subsection for a family
12 under a class of family enrollment is equal to—

13 (A) 20 percent of—

14 (i) for a family enrolled in a commu-
15 nity-rated plan offered in a community-rat-
16 ing area, the weighted average premium
17 for community-rated plans offered in the
18 community-rating area, increased by any
19 amount provided under paragraph (2); or

20 (ii) for a family enrolled in an experi-
21 ence-rated plan offered in a premium area,
22 the weighted average premium for experi-
23 ence-rated plans offered by the employer in
24 the premium area (as determined under
25 section 5131(b)(1)(A)) or, if less, the

1 amount determined under clause (i) for the
2 community-rating area in which the family
3 resides;

4 reduced (but not below zero) by—

5 (B) the sum of—

6 (i) the family obligation amount de-
7 scribed in subsection (c); and

8 (ii) the amount of any employer pay-
9 ment (not required under part 2) towards
10 the family share of premiums for covered
11 members of the family.

12 (2) INCREASE FOR COMMUNITY-RATED FAMI-
13 LIES TO ASSURE ENROLLMENT IN AT-OR-BELOW-AV-
14 ERAGE-COST PLAN.—In the case of a family enrolled
15 in a community-rated plan, if a State determines
16 that a family eligible for a discount under this sec-
17 tion is unable to enroll in an at-or-below-average-
18 cost plan (as defined in paragraph (3)) that serves
19 the area in which the family resides, the amount of
20 the premium discount under this subsection is in-
21 creased to the extent that such amount will permit
22 the family to enroll in a community-rated plan with-
23 out the need to pay a family share of premium
24 under this part in excess of the sum described in
25 paragraph (1)(B).

1 (3) AT-OR-BELOW-AVERAGE-COST PLAN DE-
 2 FINED.—In this section, the term “at-or-below-aver-
 3 age-cost plan” means a community-rated plan the
 4 premium for which does not exceed, for the class of
 5 family enrollment involved, the weighted average
 6 premium for the community-rating area.

7 (c) FAMILY OBLIGATION AMOUNT.—

8 (1) DETERMINATION.—Subject to paragraphs
 9 (2) and (3), the family obligation amount under this
 10 subsection is determined as follows:

11 (A) NO OBLIGATION IF INCOME BELOW IN-
 12 COME THRESHOLD AMOUNT OR IF AFDC OR SSI
 13 FAMILY.—If the family adjusted income (as de-
 14 fined in section 5302(d)) of the family is less
 15 than the income threshold amount (specified in
 16 paragraph (4)) or if the family is an AFDC or
 17 SSI family, the family obligation amount is
 18 zero.

19 (B) INCOME ABOVE INCOME THRESHOLD
 20 AMOUNT.—If such income is at least such in-
 21 come threshold amount and the family is not an
 22 AFDC or SSI family, the family obligation
 23 amount is the sum of the following:

24 (i) FOR INCOME (ABOVE INCOME
 25 THRESHOLD AMOUNT) UP TO THE POV-

1 ERTY LEVEL.—The product of the initial
 2 marginal rate (specified in paragraph (2))
 3 and the amount by which—

4 (I) the family adjusted income
 5 (not including any portion that ex-
 6 ceeds the applicable poverty level for
 7 the class of family involved), exceeds;
 8 (II) such income threshold
 9 amount.

10 (ii) GRADUATED PHASE OUT OF DIS-
 11 COUNT UP TO 150 PERCENT OF POVERTY
 12 LEVEL.—The product of the final marginal
 13 rate (specified in paragraph (2)) and the
 14 amount by which the family adjusted in-
 15 come exceeds 100 percent (but is less than
 16 150 percent) of the applicable poverty
 17 level.

18 (2) MARGINAL RATES.—In paragraph (1), for a
 19 year:

20 (A) INITIAL MARGINAL RATE.—The initial
 21 marginal rate is the ratio of—

22 (i) 3 percent of the applicable poverty
 23 level for the class of enrollment involved
 24 for the year; to

1 (ii) the amount by which such poverty
2 level exceeds such income threshold
3 amount.

4 (B) FINAL MARGINAL RATE.—The final
5 marginal rate is 5.7 percent.

6 (3) LIMITATION TO 3.9 PERCENT FOR ALL FAM-
7 ILIES.—

8 (A) IN GENERAL.—In no case shall the
9 family obligation amount under this subsection
10 for the year exceed 3.9 percent.

11 (B) INDEXING OF PERCENTAGE.—

12 (i) IN GENERAL.—The percentage
13 specified in subparagraph (A) shall be ad-
14 justed for any year after 1995 so that the
15 percentage for the year bears the same
16 ratio to the percentage so specified as the
17 ratio of—

18 (I) 1 plus the general health care
19 inflation factor (as defined in section
20 5001(a)(3)) for the year, bears to

21 (II) 1 plus the percentage speci-
22 fied by the Secretary in the establish-
23 ment of cost sharing schedules in sub-
24 title B of title I (relating to indexing

1 of dollar amounts related to cost shar-
2 ing) for the year.

3 (ii) ROUNDING.—Any adjustment
4 under clause (i) for a year shall be round-
5 ed to the nearest multiple of $\frac{1}{10}$ of 1 per-
6 centage point.

7 (4) INCOME THRESHOLD AMOUNT.—

8 (A) IN GENERAL.—For purposes of this
9 subtitle, the income threshold amount specified
10 in this paragraph is \$1,000 (adjusted under
11 subparagraph (B)).

12 (B) INDEXING.—For the 1-year period be-
13 ginning on January 1, 1996, the income thresh-
14 old amount specified in subparagraph (A) shall
15 be increased or decreased by the same percent-
16 age as the percentage increase or decrease by
17 which the average CPI (described in section
18 1702(12)) for the 12-month-period ending with
19 August 31 of the preceding year exceeds such
20 average for the 12-month period ending with
21 August 31, 1994.

22 (C) ROUNDING.—Any increase or decrease
23 under subparagraph (B) for a year shall be
24 rounded to the nearest multiple of \$10.

1 **Subpart B—Repayment of Family Credit by Certain**
2 **Families**

3 **SEC. 5110. REPAYMENT OF FAMILY CREDIT BY CERTAIN**
4 **FAMILIES.**

5 (a) IN GENERAL.—Subject to the succeeding provi-
6 sions of this subpart, each family which is provided a fam-
7 ily credit under section 5102 for a class of enrollment is
8 liable for repayment of an amount equal to the base em-
9 ployment monthly premium (applicable to such class) for
10 the month under section 5122.

11 (b) REDUCTION FOR SELF-EMPLOYMENT PAY-
12 MENTS.—The liability of a family under this section for
13 a year shall be reduced (but not below zero) by the amount
14 of any employer payments made in the year under section
15 5126 based on the net earnings from self-employment of
16 a family member.

17 **SEC. 5111. NO LIABILITY FOR FAMILIES EMPLOYED FULL-**
18 **TIME; REDUCTION IN LIABILITY FOR PART-**
19 **TIME EMPLOYMENT.**

20 (a) IN GENERAL.—The amount of any liability under
21 section 5110 shall be reduced, in accordance with rules
22 established by the Secretary consistent with this section,
23 based on employer premiums payable under section 5121
24 with respect to the employment of a family member who
25 is a qualifying employee or with respect to a family mem-

ber. In no case shall the reduction under this section result in any payment owing to a family.

(b) CREDIT FOR FULL-TIME AND PART-TIME EMPLOYMENT.—

(1) IN GENERAL.—Under rules of the Secretary, in the case of a family enrolled under a class of family enrollment, if a family member is a qualifying employee for a month and the employer is liable for payment under section 5121 based on such employment—

(A) FULL-TIME EMPLOYMENT CREDIT.—If the employment is on a full-time basis (as defined in section 1701(b)(2)(A)) the liability under section 5110 shall be reduced by the credit amount described in subparagraph (C).

(B) PART-TIME EMPLOYMENT CREDIT.—If the employment is on a part-time basis (as defined in section 1701(b)(2)(A)) the liability under section 5110 shall be reduced by the employment ratio of the credit amount described in subparagraph (C).

(C) FULL-TIME MONTHLY CREDIT.—The amount of the credit under this subparagraph, with respect to employment by an employer in a month, is $\frac{1}{12}$ (or, if applicable, the fraction

1 described in paragraph (2)) of the amount owed
2 under section 5110, based on the class of en-
3 rollment, for the year.

4 (2) COVERAGE DURING ONLY PART OF A
5 YEAR.—In the case of a family that is not enrolled
6 in a community-rated health plan for all the months
7 in a year, the fraction described in this paragraph
8 is 1 divided by the number of months in the year in
9 which the family was enrolled in such a plan.

10 **SEC. 5112. LIMITATION OF LIABILITY BASED ON INCOME.**

11 (a) IN GENERAL.—In the case of an eligible family
12 described in subsection (b), the repayment amount re-
13 quired under this subpart (after taking into account any
14 work credit earned under section 5111) with respect to
15 a year shall not exceed the amount of liability described
16 in subsection (c) for the year.

17 (b) ELIGIBLE FAMILY DESCRIBED.—An eligible fam-
18 ily described in this subsection is a family which is deter-
19 mined by the State for the community rating area in which
20 the family resides, to have wage-adjusted income (as de-
21 fined in subsection (d)) below 300 percent of the applica-
22 ble poverty level.

23 (c) AMOUNT OF LIABILITY.—

24 (1) DETERMINATION.—Subject to subsection
25 (f), in the case of a family enrolled in a class of en-

1 rollment with wage-adjusted income (as defined in
2 subsection (d)), the amount of liability under this
3 subsection is determined as follows:

4 (A) NO OBLIGATION IF INCOME BELOW IN-
5 COME THRESHOLD AMOUNT OR IF AFDC OR SSI
6 FAMILY.—If such income is than the income
7 threshold amount (specified in section
8 5103(c)(4)) or if the family is an AFDC or SSI
9 family, the amount of liability is zero.

10 (B) INCOME ABOVE INCOME THRESHOLD
11 AMOUNT.—If such income is at least such in-
12 come threshold amount and the family is not an
13 AFDC or SSI family, the amount of liability is
14 the sum of the following:

15 (i) FOUR PERCENT OF INCOME
16 (ABOVE INCOME THRESHOLD AMOUNT) UP
17 TO THE POVERTY LEVEL.—The initial
18 marginal rate (specified in paragraph
19 (2)(A)) of the amount by which—

20 (I) the wage-adjusted income
21 (not including any portion that ex-
22 ceeds the applicable poverty level for
23 the class of family involved), exceeds

24 (II) such income threshold
25 amount.

1 (ii) SECOND MARGINAL RATE.—The
 2 second marginal rate (specified in para-
 3 graph (2)(B) of the amount by which—

4 (I) the wage adjusted income
 5 (not including any portion that ex-
 6 ceeds twice the applicable poverty
 7 level for the class of family involved),
 8 exceeds

9 (II) the applicable poverty level
 10 for the class of family enrollment.

11 (iii) FINAL MARGINAL RATE.—Where
 12 wage-adjusted income exceeds 200 percent
 13 of the applicable poverty level, the final
 14 marginal rate (specified in paragraph
 15 (2)(C)) of the amount by which the wage-
 16 adjusted income exceeds 100 percent of the
 17 applicable poverty level.

18 (2) MARGINAL RATES.—In paragraph (1)—

19 (A) INITIAL MARGINAL RATE.—The initial
 20 marginal rate, for a year for a class of enroll-
 21 ment, is the ratio of—

22 (i) 4 percent of the applicable poverty
 23 level for the class of enrollment for the
 24 year, to

1 (ii) the amount by which such poverty
2 level exceeds such income threshold
3 amount.

4 (B) SECOND MARGINAL RATE.—The sec-
5 ond marginal rate, for a year for the class of
6 enrollment, is 7.6 percent.

7 (C) FINAL MARGINAL RATE.—The final
8 marginal rate, for a year for a class of enroll-
9 ment, is the ratio of—

10 (i) the amount by which (I) the
11 amount of the repayment amount de-
12 scribed in section 5111(a) exceeds (II) 5.8
13 percent of twice the applicable poverty level
14 (for the class and year); to

15 (ii) 200 percent of such poverty level.

16 (3) SECOND MARGINAL RATE.—

17 (A) IN GENERAL.—If, for a class of enroll-
18 ment for a community rating area in a State,
19 the second marginal rate exceeds the final mar-
20 ginal rate, the State may adjust such marginal
21 rates so that the second marginal rate and the
22 final marginal rate are the same and equal to
23 the ratio of—

24 (i) the amount by which (I) the
25 amount of the repayment amount de-

1 scribed in section 5111(a) exceeds (II) 4
2 percent of the applicable poverty level (for
3 the class and year); to

4 (ii) 200 percent of such poverty level.

5 (d) WAGE-ADJUSTED INCOME DEFINED.—In this
6 subtitle, the term “wage-adjusted income” means, for a
7 family, family adjusted income of the family, reduced by
8 the sum of the following:

9 (1)(A) Subject to subparagraph (B), the
10 amount of any wages included in such family’s in-
11 come that is received for employment which is taken
12 into account in the computation of the amount of
13 employer premiums under section 5121 (without
14 consideration of section 5125).

15 (B) The reduction under subparagraph (A)
16 shall not exceed for a year \$5,000 (adjusted under
17 section 5103(c)(3)(B)) multiplied by the number of
18 months (including portions of months) of employ-
19 ment with respect to which employer premiums were
20 payable under section 5121 (determined in a manner
21 consistent with section 1701(b)(3)).

22 (2) The amount of net earnings from self em-
23 ployment of the family taken into account under sec-
24 tion 5125.

1 (3) The amount of unemployment compensation
2 included in income under section 85 of the Internal
3 Revenue Code of 1986.

4 **SEC. 5113. PAYMENTS BY NONQUALIFYING EMPLOYEES.**

5 (a) IN GENERAL.—In the case of an eligible family
6 described in paragraph (b), the net liability of the family
7 under this section shall be the amount described in sub-
8 section (c), limited by the amount described in subsection
9 (d) plus the amount described in subsection (e).

10 (b) ELIGIBLE FAMILY DESCRIBED.—The family de-
11 scribed in this paragraph is a family that has one or more
12 nonqualifying employees and has no full-time qualifying
13 employees. The Secretary shall develop rules for applying
14 this section to families whose employment status with re-
15 spect to exempt employers changes during the year.

16 (c) AMOUNT.—The amount described in this sub-
17 section is the sum of—

18 (1) the family share as defined in section 5101
19 (including any discounts under 5103); and

20 (2) the family credit repayment amount de-
21 scribed in subpart B of title VI (including any re-
22 ductions under section 5103); reduced by—

23 (3) the amount (if any) by which that the pre-
24 mium with respect to such family exceeds the
25 weighted average premium (applicable to the family).

1 (d) LIMIT.—The limit described in this subsection is
2 the following:

3 (1) for a family with family adjusted income of
4 less than 150 percent of the applicable poverty level,
5 4 percent of family adjusted income;

6 (2) for a family with family adjusted income of
7 at least 150 percent but less than 175 percent of the
8 applicable poverty level, 4.5 percent of family ad-
9 justed income;

10 (3) for a family with family adjusted income of
11 at least 175 percent but less than 225 percent of the
12 applicable poverty level, 5 percent of family adjusted
13 income; and

14 (4) for a family with family adjusted income of
15 at least 225 percent but less than 400 percent of the
16 applicable poverty level, 6 percent of family adjusted
17 income.

18 (e) The amount described in this subsection is the
19 amount in subsection (c)(3).

20 (f) INDEXING OF PERCENTAGES.—

21 (1) IN GENERAL.—The percentage of family ad-
22 justed income specified in paragraphs (1) through
23 (4) of subsection (d) shall be adjusted for any year
24 after 1994 so that the percentage for the year bears

1 the same ratio to the percentage so specified as the
2 ratio of—

3 (A) 1 plus the general health care inflation
4 factor (as defined in section 5001(a)(3)) for the
5 year, bears to

6 (B) 1 plus the percentage specified by the
7 Secretary in the establishment of cost sharing
8 schedules in subtitle B of title I.

9 (2) ROUNDING.—Any adjustment under para-
10 graph (1) for a year shall be rounded to the nearest
11 multiple of $\frac{1}{10}$ of 1 percentage point.

12 **SEC. 5114. SPECIAL TREATMENT OF CERTAIN MEDICARE**
13 **BENEFICIARIES.**

14 In the case of an individual who would be a medicare-
15 eligible individual in a month but for the application of
16 section 1012(a) on the basis of employment (in the month
17 or a previous month) of the individual or the individual's
18 spouse or parent, the individual (or spouse or parent, as
19 the case may be) so employed is considered, for purposes
20 of section 5112, to be a full-time employee described in
21 such section in such month.

1 **PART 2—EMPLOYER PREMIUM PAYMENTS**

2 **Subpart A—Small Business Exemption**

3 **SEC. 5116. EXEMPTION FROM COVERAGE OBLIGATIONS.**

4 An exempt employer as defined section 5117 shall be
5 exempt from requirements described in this part, unless
6 the employer elects under section 5118 to be treated as
7 a community-rated employer.

8 **SEC. 5117. EXEMPT EMPLOYER DEFINED.**

9 (a) IN GENERAL.—In this section—

10 (1) the term “exempt employer” means an em-
11 ployer that does not employ, on average, more than
12 10 full-time equivalent employees;

13 (2) and is an employer with average annual
14 wages per full-time equivalent employee of less than
15 \$24,000; and

16 (3) the average number of full-time equivalent
17 employees shall be determined by averaging the
18 number of full-time equivalent employees employed
19 by the employer in each countable month during the
20 year.

21 (b) DETERMINATIONS.—The number of full-time
22 equivalent employees shall be determined using the rules
23 under section 1701(b)(2).

24 (c) EXEMPT EMPLOYER.—The term “exempt em-
25 ployer” shall not include an individual described in section
26 5126(c)(2).

1 **SEC. 5118. ELECTION.**

2 A exempt employer may elect to be treated as a com-
3 munity-rated employer under the procedures determined
4 by the Secretary.

5 **SEC. 5119. TREATMENT OF EXEMPT EMPLOYERS.**

6 (a) IN GENERAL.—

7 (1) COMMUNITY RATED EMPLOYER.—An ex-
8 empt employer shall be treated as a community
9 rated employer as of the first date of the first year
10 following an election made under section 5118.

11 (2) ELIGIBILITY FOR DISCOUNTS.—An exempt
12 employer making an election under section 5118
13 shall be eligible for discounts under 5123.

14 **SEC. 5120. NONELECTING EXEMPT EMPLOYER.**

15 (a) IN GENERAL.—The term “nonelecting exempt
16 employer” means an exempt employer that has not made
17 an election under section 5118.

18 (b) APPLICATION OF RULES SIMILAR TO MEDICARE
19 NONDISCRIMINATION RULES TO NON-ELECTING EM-
20 PLOYERS.—Subject to subsection (b), the provisions of
21 paragraphs (1)(A), (1)(D), (1)(E), (3)(A), and (3)(C) of
22 section 1862(b) of the Social Security Act shall apply to
23 an individual eligible for premium assistance under this
24 title in relation to any non-electing employer in the same
25 manner as such provisions apply to an individual age 65
26 or over who is entitled to benefits under title XVIII of

1 such Act under section 226(a) of such Act in relation to
2 such employer.

3 **Subpart B—Community-Rated Employers**

4 **SEC. 5121. EMPLOYER PREMIUM PAYMENT REQUIRED.**

5 (a) REQUIREMENT.—

6 (1) IN GENERAL.—Each community-rated em-
7 ployer described in paragraph (2) for a month shall
8 pay at least an amount equal to the sum across all
9 qualifying employees of the amount specified in sub-
10 section (b) for each such qualifying employee of the
11 employer.

12 (2) EMPLOYER DESCRIBED.—An employer de-
13 scribed in this paragraph for a month is an employer
14 that—

15 (A) in a month employs one or more quali-
16 fying employees (as defined in section
17 1701(b)(1)); and

18 (B) is not exempt under section 3127 of
19 the Internal Revenue Code of 1986 from the
20 taxes imposed in section 3111 of such code.

21 (3) TREATMENT OF CERTAIN EMPLOYMENT BY
22 EXPERIENCE-RATED EMPLOYERS.—An experience-
23 rated employer shall be deemed, for purposes of this
24 subpart, to be a community-rated employer with re-

1 spect to qualifying employees who are not experience
2 rate eligible individuals.

3 (b) PREMIUM PAYMENT AMOUNT.—

4 (1) IN GENERAL.—Except as provided in sec-
5 tion 5123 (relating to a discount for certain employ-
6 ers), the amount of the employer premium payment,
7 for a month for each qualifying employee of the em-
8 ployer who is residing in a community rating area,
9 is the payment amount computed under paragraph
10 (2) with respect to such employee in such area.

11 (2) PAYMENT AMOUNT FOR EACH EMPLOYEE IN
12 A CLASS OF FAMILY ENROLLMENT.—The payment
13 amount under this paragraph, for an employer for
14 each qualifying employee residing in a community
15 rating area, is the product of—

16 (A) the base employment monthly premium
17 determined under section 5122 for the applica-
18 ble class of family enrollment for the previous
19 month for the community rating area, and

20 (B) the full-time employment ratio (as de-
21 fined in section 1701 for the previous month.

22 (3) SPECIAL RULES FOR DIVIDED FAMILIES.—
23 In the case of an individual who is a qualifying em-
24 ployee of an employer, if the individual has a spouse

1 or child who is not treated as part of the individual's
 2 family because of section 1012—

3 (A) the employer premium payment under
 4 this section shall be computed as though such
 5 section had not applied, and

6 (B) the State shall provide for proportional
 7 payments (consistent with rules established by
 8 the Secretary) to the health plans (if different)
 9 of the qualifying employee and of the employ-
 10 ee's spouse and children.

11 **SEC. 5122. COMPUTATION OF BASE EMPLOYMENT MONTH-**
 12 **LY PREMIUM.**

13 Each State shall provide for the computation for each
 14 year (beginning with the first year) of a base employment
 15 monthly premium for each class of family enrollment equal
 16 to $\frac{1}{12}$ of 80 percent of the weighted average premium for
 17 the community rating area for such class of enrollment
 18 adjusted to account for the average number of workers
 19 per family within such class. Any such adjustment made
 20 regarding the dual parent family class of enrollment shall
 21 also be made to the single parent family class.

22 **SEC. 5123. PREMIUM DISCOUNT FOR CERTAIN EMPLOYERS.**

23 (a) EMPLOYER DISCOUNT.—

24 (1) IN GENERAL.—Subject to section 5124(c),
 25 the amount of the employer premium payment re-

1 quired under section 5121(b) for a community-rated
 2 employer for any year for a qualifying employee
 3 shall not exceed the limiting percentage (as defined
 4 in subsection (b)) of such qualifying employee's
 5 wages for that year.

6 (2) EXCLUSION OF FEDERAL GOVERNMENT EM-
 7 PLOYERS.—Paragraph (1) shall not apply to the
 8 Federal Government.

9 (b) LIMITING PERCENTAGE DEFINED.—In sub-
 10 section (a)—

11 (1) ANY EMPLOYER.—For an employer that is
 12 not a medium-sized employer (as defined in sub-
 13 section (c)) or an exempt employer (as defined in
 14 subsection 5117), the limiting percentage is 12 per-
 15 cent.

16 (2) MEDIUM-SIZED EMPLOYERS.—For an em-
 17 ployer that is a medium-sized employer and that has
 18 an average number of full-time equivalent employees
 19 and average annual wages per full-time equivalent
 20 employee (as determined under subsection (d)), the
 21 limiting percentage is the applicable percentage de-
 22 termined based on following table:

Average number of full-time equivalent employees	\$0– \$12,000	\$12,001– \$15,000	\$15,001– \$18,000	\$18,001– \$21,000	\$21,001– \$24,000	\$24,001 or more
Fewer than 15	4.2%	5.5%	6.8%	8.1%	9.4%	12%

Average number of full-time equivalent employees	\$0– \$12,000	\$12,001– \$15,000	\$15,001– \$18,000	\$18,001– \$21,000	\$21,001– \$24,000	\$24,001 or more
15 but fewer than 25	5.5%	6.8%	8.1%	9.4%	10.7%	12%
25 but fewer than 50	6.8%	8.1%	9.4%	10.7%	12%	12%
50 but not over 75	8.1%	9.4%	10.7%	12%	12%	12%

1 (3) SMALL EMPLOYERS.—For an employer that
2 is an exempt employer and elects to be a commu-
3 nity-rated employer (in accordance of section
4 5119), the limiting percentage is the limiting per-
5 centage described in paragraph (2).

6 (4) EXPERIENCE-RATED EMPLOYERS.—The
7 value of discounts provided to an experience-rated
8 employer shall not exceed the amount that the em-
9 ployer would receive if the employer was treated as
10 a community-rated employer.

11 (c) MEDIUM-SIZED EMPLOYER DEFINED.—

12 (1) IN GENERAL.—In this section, the term
13 “medium-sized employer” means an employer that
14 does not employ, on average, less than 11 full-time
15 equivalent employees or more than 75 full-time
16 equivalent employees.

17 (2) DETERMINATIONS.—The number of full-
18 time equivalent employees shall be determined using
19 the rules under section 1701(b)(2).

1 (d) AVERAGE ANNUAL WAGES PER FULL-TIME
2 EQUIVALENT EMPLOYEE DEFINED.—

3 (1) IN GENERAL.—In this section, the term
4 “average annual wages per full-time equivalent em-
5 ployee” means, for an employer for a year—

6 (A) the total wages paid in the year to in-
7 dividuals who, at the time of payment of the
8 wages, are qualifying employees of the em-
9 ployer; divided by

10 (B) the number of full-time equivalent em-
11 ployees of the employer in the year.

12 (2) DETERMINATION.—The Secretary may es-
13 tablish rules relating to the computation of the aver-
14 age annual wages for employers.

15 (e) TREATMENT OF CERTAIN SELF-EMPLOYED INDIV-
16 IDUALS.—In the case of an individual who is a partner
17 in a partnership, is a 2-percent shareholder in an S cor-
18 poration (within the meaning of section 1372 of the Inter-
19 nal Revenue Code of 1986), or is any other individual who
20 carries on a trade or business as a sole proprietorship,
21 for purposes of this section—

22 (1) the individual is deemed to be an employee
23 of the partnership, S corporation, or proprietorship,
24 and

1 (2) the individual's net earnings from self em-
2 ployment attributable to the partnership, S corpora-
3 tion, or sole proprietorship are deemed to be wages
4 from the partnership, S corporation, or proprietor-
5 ship.

6 (f) APPLICATION TO EMPLOYERS.—An employer that
7 claims that this section applies—

8 (1) shall provide notice to the State of the claim
9 at the time of making payments under this subpart;
10 and

11 (2) shall make available such information (and
12 provide access to such information) as the State may
13 require (in accordance with regulations of the Sec-
14 retary of Labor) to audit the determination of—

15 (A) whether the employer is a medium em-
16 ployer, and, if so, the average number of full-
17 time equivalent employees and average annual
18 wages of the employer; and

19 (B) the total wages paid by the employer
20 for qualifying employees.

21 (g) TREATMENT OF MULTI-AREA EMPLOYERS.—In
22 the case in which this section is applied to an employer
23 that makes employer premium payments in more than one
24 community rating areas, the reduction under this section

1 shall be applied in a pro-rated manner to the premium
2 payments made to all such areas.

3 **SEC. 5124. PAYMENT ADJUSTMENT FOR CERTAIN LARGE**
4 **EMPLOYERS.**

5 If the Secretary determines that the average antici-
6 pated cost for employees (and dependents of such employ-
7 ees) of an employer described in section 5022 exceeds the
8 anticipated average cost for all community-rate eligible in-
9 dividuals residing in the area, including costs to the gov-
10 ernment, such employee's payments shall be adjusted by
11 an amount determined appropriate by the Secretary.

12 **SEC. 5125. APPLICATION TO SELF-EMPLOYED INDIVIDUALS.**

13 (a) IN GENERAL.—A self-employed individual (as de-
14 fined in section 1701(c)(2)) shall be considered, for pur-
15 poses of this subpart to be an employer of himself or her-
16 self and to pay wages to himself or herself equal to the
17 amount of net earnings from self-employment (as defined
18 in section 1701(c)(1)).

19 (b) SPECIAL RULE FOR CERTAIN SELF-EMPLOYED
20 INDIVIDUALS.—

21 (1) IN GENERAL.—In the case of certain self-
22 employed individuals described in paragraph (2), the
23 payment obligation under this section shall be lim-
24 ited to the liability described in subsection (c) of sec-
25 tion 5113 (substituting the amount of net earnings

1 from self employment (defined in section 1701(c)(1))
2 of such individual for wage adjusted income).

3 (2) SELF-EMPLOYED INDIVIDUALS.—The indi-
4 viduals described in this paragraph are self-employed
5 individuals (as defined in section 1701(c)(2)) for a
6 year who are not employers with respect to other
7 qualifying employees in such year.

8 (3) SPECIAL RULE FOR CERTAIN CLOSELY-
9 HELD BUSINESSES.—

10 (A) IN GENERAL.—In the case of an indi-
11 vidual who—

12 (i) has wage-adjusted income (as de-
13 fined in section 5113(d), determined with-
14 out regard to paragraphs (1)(B) and (2)
15 thereof) that exceeds 300 percent (or such
16 higher percentage as the Secretary may es-
17 tablish) of the applicable poverty level, and

18 (ii) is both a substantial owner and an
19 employee of a closely held business,

20 the amount of any reduction under paragraph
21 (1)(A) that is attributable to the individual's
22 employment by that business shall be appro-
23 priately reduced in accordance with rules pre-
24 scribed by the Secretary, in order to prevent in-
25 dividuals from avoiding payment of the full

1 amount owed through fraudulent or secondary
2 employment arrangements.

3 (B) CLOSELY HELD BUSINESS.—For pur-
4 poses of subparagraph (A), a business is “close-
5 ly held” if it is an employer that meets the re-
6 quirements of section 542(a)(2) of the Internal
7 Revenue Code of 1986 or similar requirements
8 as appropriate in the case of a partnership or
9 other entity.

10 **Subpart C—Large Employers**

11 **SEC. 5131. LARGE EMPLOYER PREMIUM PAYMENT RE-**
12 **QUIRED.**

13 (a) PER EMPLOYEE PREMIUM PAYMENT.—Subject
14 to section 5124, each experience-rated large employer that
15 in a month in a year employs a qualifying employee who
16 is—

17 (1) enrolled in an experience-rated health plan,
18 shall provide for a payment toward the premium for
19 the plan for such employee in an amount at least
20 equal to the large employer premium payment speci-
21 fied in subsection (b); or

22 (2) is not so enrolled, shall make employer pre-
23 mium payments with respect to such employment
24 under subpart B in the same manner as if the em-

1 ployer were a community-rated employer (except as
2 otherwise provided in such subpart).

3 (b) LARGE EMPLOYER PREMIUM.—

4 (1) AMOUNT.—

5 (A) IN GENERAL.—The amount of the
6 large employer premium payment for a month
7 in a year for a class of family enrollment for a
8 family residing in a geographic area is 80 per-
9 cent of the weighted average monthly premium
10 of the experience-rated health plans offered by
11 the large employer for that class of enrollment
12 for families residing in that area.

13 (B) APPLICATION TO SELF-INSURED
14 PLANS.—In applying this paragraph in the case
15 of one or more experience-rated health plans
16 that are self-insured plans—

17 (i) the “premium” for the plan is the
18 actuarial equivalent of such premium,
19 based upon the methodology (or such other
20 consistent methodology) used under section
21 5021(a); and

22 (ii) the premium amount, for different
23 classes and, if applicable, for different pre-
24 mium areas, shall be computed in a man-
25 ner based on such factors as may bear a

1 reasonable relationship to costs for the
2 provision of the benefit package to the dif-
3 ferent classes in such areas.

4 The Secretary of Labor shall establish rules to
5 carry out this subparagraph.

6 (2) LOW-INCOME EMPLOYEES.—In the case of a
7 low-income employee entitled to a premium discount
8 under section 5103(a), the amount of the employer
9 premium payment for a month in a year for a class
10 of family enrollment shall be increased by the
11 amount of such premium discount.

12 (c) DETERMINATIONS.—Determinations under this
13 section shall be made based on such information as the
14 Secretary of Labor shall specify.

15 **Subtitle C—Payments to Health**
16 **Plans and Miscellaneous Provi-**
17 **sions**

18 **SEC. 5201. ASSISTANCE TO PLANS.**

19 States shall be responsible for assisting health plans
20 and cooperatives in the collection of premium payments.
21 A State may establish administrative systems (including
22 arrangements with private entities) to facilitate the collec-
23 tion of premiums from employers and families and the dis-
24 tribution of such premiums to health plans, consistent
25 with rules promulgated by the Secretary.

1 **SEC. 5202. COMPUTATION OF BLENDED PLAN PAYMENT**
2 **AMOUNT.**

3 (a) IN GENERAL.—For purposes of section 5203, the
4 payment amount for a community-rated health plan in a
5 community rating area in a year is equal to a blended pay-
6 ment amount reflecting the final accepted bid for each
7 plan, the number of enrollees in each premium class, and
8 the proportion of AFDC and SSI beneficiaries throughout
9 the community rating area served by the plan.

10 (b) METHODOLOGY.—The Secretary shall establish a
11 methodology by which the blended payment amount de-
12 scribed in subsection (a) shall be computed and applied.

13 **SEC. 5203. ADJUSTMENT TO HEALTH PLAN REVENUES**

14 (a) IN GENERAL.—States shall develop and imple-
15 ment revenue adjustment mechanisms and collect such in-
16 formation as may be necessary for ensuring that payments
17 to health plans are appropriate and sufficient.

18 (b) ADJUSTMENTS.—Mechanisms under subsection
19 (a) shall include methods for risk adjustment and reinsur-
20 ance (in accordance with title I), the payment of premium
21 discounts (in accordance with subtitle B of title VI), pay-
22 ment adjustments to reflect each area's share of AFDC
23 and SSI beneficiaries (in accordance with section 5202),
24 and other adjustments necessary to reconcile the amounts
25 collected by plans with the amounts plans are owed.

1 **SEC. 5204. CALCULATION AND PUBLICATION OF GENERAL**
2 **FAMILY SHARE AND GENERAL EMPLOYER**
3 **PREMIUM AMOUNTS.**

4 (a) FAMILY SHARE.—Each State shall compute and
5 publish the following components of the general family
6 share of premiums for each community rating area des-
7 ignated by the State:

8 (1) PLAN PREMIUMS.—For each plan offered,
9 the applicable premiums for such plan for each class
10 of family enrollment (including the amount of any
11 family collection shortfall).

12 (2) QUALIFIED WORKSITE HEALTH PRO-
13 MOTION.—For each plan offered, the premium dis-
14 count for each level of qualified worksite health pro-
15 motion program.

16 (3) FAMILY CREDIT.—The family credit amount
17 for each class of family enrollment, under section
18 5102.

19 (b) EMPLOYER PREMIUMS.—Each State shall com-
20 pute and publish the following components of the general
21 employer premium payment amount for each community
22 rating area designated by the State:

23 (1) BASE EMPLOYER MONTHLY PREMIUM PER
24 WORKER.—The base employer monthly premium de-
25 termined under section 5122 for each class of family
26 enrollment.

1 (2) QUALIFIED WORKSITE HEALTH PRO-
2 MOTION.—The base monthly premium discount for
3 each level of qualified worksite health promotion pro-
4 gram.

5 (c) RECONCILIATION OF FAMILY SHARE.—Each
6 State shall provide for the reconciliation of family pay-
7 ments in cases where the State determines that there has
8 been an overpayment or underpayment by or on the behalf
9 of such families in accordance with rules promulgated by
10 the Secretary.

11 **SEC. 5205. EMPLOYER PAYMENT REQUIREMENT.**

12 (a) IN GENERAL.—Each employer shall provide for
13 payments required under section 5121 or 5131 in accord-
14 ance with the applicable provisions of this Act.

15 (b) EMPLOYERS IN SINGLE-PAYER STATES.—In the
16 case of an employer with respect to employees who reside
17 in a single-payer State, the responsibilities of such em-
18 ployer under such system shall supersede the obligations
19 of the employer under subsection (a), except as the Sec-
20 retary may provide.

21 **SEC. 5206. REQUIREMENT FOR EMPLOYER PAYMENT AND**
22 **RECONCILIATION REPORTING.**

23 (a) RECONCILIATION OF EMPLOYER PREMIUM PAY-
24 MENTS.—Each employer (whether or not the employer
25 claimed (or claims) an employer premium discount under

1 section 5123 for a year) that is liable for employer pre-
2 mium payments for any month in a year shall provide such
3 information as may be required (consistent with rules of
4 the Secretary of Labor) to determine—

5 (1) the amount of employee premium payments
6 made for all months in the year (taking into account
7 any employer premium discount under section
8 5123); and

9 (2) the appropriate amount of employer pre-
10 mium payments that should have been made for all
11 months in the year. Such reconciliation process shall
12 be conducted by the State (with respect to commu-
13 nity-rated employers) and by the Secretary of Labor
14 (with respect to experience-rated employers).

15 (b) NOTICE TO CERTAIN INDIVIDUALS WHO ARE
16 NOT EMPLOYEES.—

17 (1) IN GENERAL.—A person that carries on a
18 trade or business shall notify in writing each individ-
19 ual described in paragraph (2) that the person is not
20 obligated to make any employer health care premium
21 payment (under section 5121) in relation to the
22 services performed by the individual for the person.

23 (2) INDIVIDUAL DESCRIBED.—An individual de-
24 scribed in this paragraph, with respect to a person,
25 is an individual who normally performs services for

1 the person in the person's trade or business for more
 2 than 40 hours per month but who is not an em-
 3 ployee of the person (within the meaning of section
 4 1701(a)).

5 (3) EXCEPTIONS.—The Secretary shall issue
 6 regulations providing exceptions to the notice re-
 7 quirement of paragraph (1) with respect to individ-
 8 uals performing services on an irregular, incidental,
 9 or casual basis.

10 (4) MODEL NOTICE.—The Secretary shall pub-
 11 lish a model notice that is easily understood by the
 12 average reader and that persons may use to satisfy
 13 the requirements of paragraph (1).

14 (c) INFORMATION CLEARINGHOUSE FUNCTIONS.—
 15 The Secretary shall perform information clearinghouse
 16 functions under this section with respect to employers,
 17 States, the Federal Government, and consumer purchas-
 18 ing cooperatives.

19 **SEC. 5207. EQUAL VOLUNTARY CONTRIBUTION REQUIRE-**
 20 **MENT.**

21 (a) IN GENERAL.—

22 (1) EQUAL VOLUNTARY EMPLOYER PREMIUM
 23 PAYMENT REQUIREMENT.—

24 (A) COMMUNITY-RATED HEALTH PLANS.—

25 If an employer makes available a voluntary em-

1 employer premium payment (as defined in sub-
2 section (d)) on behalf of a full-time employee
3 (as defined in section 1701(b)(2)(C)) who is en-
4 rolled in a community-rated health plan of a
5 community rating area in a class of family en-
6 rollment, the employer shall make available
7 such a voluntary employer premium payment in
8 the same dollar amount to all qualifying em-
9 ployees (as defined in section 1701(b)(1)) of the
10 employer who are enrolled in any community-
11 rated health plan of the same coverage area in
12 the same class of family enrollment.

13 (B) EXPERIENCE-RATED HEALTH
14 PLANS.—If an experience-rated employer makes
15 available a voluntary employer premium pay-
16 ment on behalf of a full-time employee who is
17 enrolled in an experience-rated health plan of a
18 large employer in a class of family enrollment
19 in a premium area, the employer shall make
20 available such a voluntary employer premium
21 payment in the same dollar amount to all quali-
22 fying employees of the employer enrolled in any
23 experience-rated health plan of the same pur-
24 chaser in the same class of family enrollment in
25 the same premium area.

1 (C) TREATMENT OF PART-TIME EMPLOY-
2 EES.—In applying subparagraphs (A) and (B)
3 in the case of a qualifying employee employed
4 on a part-time basis (within the meaning of sec-
5 tion 1701(b)(2)(A)(ii)), the dollar amount shall
6 be equal to the full-time employment ratio (as
7 defined in section 1701(b)(2)(B)) multiplied by
8 the dollar amount otherwise required.

9 (2) NONDISCRIMINATION AMONG PLANS SE-
10 LECTED.—An employer may not discriminate in the
11 wages or compensation paid, or other terms or con-
12 ditions of employment, with respect to an employee
13 based on the health plan (or premium of such a
14 plan) in which the employee is enrolled.

15 (b) REBATE REQUIRED IN CERTAIN CASES.—Subject
16 to subsection (c), if—

17 (1) an employer makes available a voluntary
18 employer premium payment on behalf of an em-
19 ployee, and

20 (2)(A) the sum of the amount of the applicable
21 family credit (under section 5102) and the voluntary
22 employer premium payment, exceeds (B) the pre-
23 mium for the plan selected,

24 the employer must rebate to the employee an amount
25 equal to the excess described in subparagraph (B).

1 (c) EXCEPTION FOR COLLECTIVE BARGAINING
2 AGREEMENT.—Subsections (a) and (b) shall not apply
3 with respect to voluntary employer premium payments
4 made pursuant to a bona fide collective bargaining agree-
5 ment.

6 (d) VOLUNTARY EMPLOYER PREMIUM PAYMENT.—
7 In this section, the term “voluntary employer premium
8 payment” means any payment designed to be used exclu-
9 sively (or primarily) towards the cost of the family share
10 of premiums for a health plan. Such term does not include
11 any employer premiums required to be paid under part
12 3 of subtitle B of title VI.

13 **SEC. 5208. PAYMENT ARRANGEMENTS.**

14 (a) WITHHOLDING.—

15 (1) IN GENERAL.—In the case of a family that
16 includes a qualifying employee of an employer, the
17 employer shall deduct from the wages of the qualify-
18 ing employee (in a manner consistent with any rules
19 of the Secretary of Labor) the amount of the family
20 share of the premium for the plan in which the fam-
21 ily is enrolled.

22 (2) MULTIPLE EMPLOYMENT.—In the case of a
23 family that includes more than one qualifying em-
24 ployee, the family shall choose the employer to which
25 paragraph (1) will apply.

1 (3) SATISFACTION OF LIABILITY.—An amount
 2 deducted from wages of a qualifying employee by an
 3 employer is deemed to have been paid by the em-
 4 ployee and to have satisfied the employee’s obliga-
 5 tion under subsection (a) to the extent of such
 6 amount.

7 (b) OTHER METHODS.—In the case of a family that
 8 does not include a qualifying employee, the State shall re-
 9 quire payment to be made prospectively. Such payment
 10 may be required to be made not less frequently than
 11 monthly. The Secretary may issue regulations in order to
 12 assure the timely and accurate collection of the family
 13 share due.

14 **Subtitle D—Cost-Sharing Assist-**
 15 **ance, Application for Assistance**
 16 **and Premium Discounts, and In-**
 17 **come Reconciliation**

18 **SEC. 5301. REDUCTION IN COST SHARING FOR LOW-INCOME**
 19 **FAMILIES.**

20 (a) REDUCTION.—

21 (1) IN GENERAL.—Subject to subsection (b), in
 22 the case of a family that is enrolled in a health plan
 23 and that is either (A) an AFDC or SSI family or
 24 (B) is determined under this subpart to have family
 25 adjusted income below 200 percent of the applicable

1 poverty level, the family is entitled to a reduction in
2 cost sharing in accordance with this section.

3 (2) TIMING OF REDUCTION.—The reduction in
4 cost sharing shall only apply to items and services
5 furnished after the date the application for such re-
6 duction is approved under section 5302 and before
7 the date of termination of the reduction under this
8 subpart, or, in the case of an AFDC or SSI family,
9 during the period in which the family is such a fam-
10 ily.

11 (3) INFORMATION TO PROVIDERS AND
12 PLANS.—Each State shall provide, through elec-
13 tronic means and otherwise, health care providers
14 and health plans with access to such information as
15 may be necessary in order to provide for the cost
16 sharing reductions under this section.

17 (b) LIMITATION.—No reduction in cost sharing under
18 subsection (c)(1) shall be available for—

19 (1) community-rated families residing in a
20 health care coverage area if the State for the area
21 determines that there are sufficient at or below aver-
22 age cost plans (as defined in section 5104(b)(3)),
23 which are plans with cost-sharing similar to the
24 model certified preferred provider network plans or
25 model certified health maintenance organization

1 plans established by the Secretary under section
 2 1101(h), available in the area to enroll AFDC and
 3 SSI families and families with family adjusted in-
 4 come below 150 percent of the applicable poverty
 5 level;

6 (2) experience-rated families whose employer of-
 7 fers a plan described in paragraph (1); or

8 (3) for families with family adjusted income be-
 9 tween 150 and 200 percent of the applicable poverty
 10 level.

11 (c) AMOUNT OF COST SHARING REDUCTION.—

12 (1) IN GENERAL.—Subject to paragraph (2),
 13 the reduction in cost sharing under this section shall
 14 be such reduction as will reduce cost sharing to the
 15 level of plans with cost-sharing similar to the model
 16 certified preferred provider network plans or model
 17 certified health maintenance organization plans es-
 18 tablished by the Secretary under section 1101(h)

19 (2) SPECIAL TREATMENT OF CERTAIN FAMI-
 20 LIES.—

21 (A) AFDC, SSI AND FAMILIES BELOW POV-
 22 ERTY.—In the case of a family that—

23 (i) is enrolled in a health plan;

24 (ii) is an AFDC, SSI family or a fam-
 25 ily that is determined under this subpart

1 to have a family adjusted income below
2 100 percent of the applicable poverty level;
3 and

4 (iii) is enrolled in a plan with cost-
5 sharing similar to the model certified pre-
6 ferred provider network plans or model
7 certified health maintenance organization
8 plans established by the Secretary under
9 section 1101(h), or receiving a reduction in
10 cost sharing under paragraph (1);

11 the amount of cost sharing applied with respect
12 to an item or service (other than with respect
13 to hospital emergency room services for which
14 there is no emergency medical condition, as de-
15 fined in section 1867(e)(1) of the Social Secu-
16 rity Act) shall be an amount equal to 20 per-
17 cent of the cost sharing amount otherwise ap-
18 plicable under the plan, rounded to the nearest
19 dollar.

20 (B) FAMILIES WITH INCOMES BETWEEN
21 100 AND 150 PERCENT OF POVERTY.—In the
22 case of a family that—

23 (i) is enrolled in a community-rated
24 health plan;

1 (ii) is determined under this subpart
2 to have family adjusted income between
3 100 and 150 percent of the applicable pov-
4 erty level;

5 (iii) is not an AFDC or SSI family;
6 and

7 (iv) is enrolled in a plan with cost-
8 sharing similar to the model certified pre-
9 ferred provider network plans or model
10 certified health maintenance organization
11 plans established by the Secretary under
12 section 1101(h), or receiving a reduction in
13 cost sharing under paragraph (1);

14 the amount of cost sharing applied with respect
15 to an item or service (other than with respect
16 to hospital emergency room services for which
17 there is no emergency medical condition, as de-
18 fined in section 1867(e)(1) of the Social Secu-
19 rity Act) shall be an amount equal to 40 per-
20 cent of the cost sharing amount otherwise ap-
21 plicable, rounded to the nearest dollar.

22 (C) FAMILIES WITH INCOMES BETWEEN
23 150 AND 200 PERCENT OF POVERTY.—In the
24 case of a family that—

1 (i) is enrolled in a community-rated
2 health plan;

3 (ii) is determined under this subpart
4 to have family adjusted income between
5 150 and 200 percent of the applicable pov-
6 erty level; and

7 (iii) is not an AFDC or SSI family;
8 the amount of cost sharing applied with respect
9 to an item or service (other than with respect
10 to hospital emergency room services for which
11 there is no emergency medical condition, as de-
12 fined in section 1867(e)(1) of the Social Secu-
13 rity Act) shall be an amount equal to 40 per-
14 cent of the cost sharing amount otherwise ap-
15 plicable under the plan, rounded to the nearest
16 dollar.

17 (d) ADMINISTRATION.—

18 (1) IN GENERAL.—In the case of an approved
19 family (as defined in section 5302(b)(2)) enrolled in
20 a community-rated health plan, the State shall pay
21 the plan for cost sharing reductions (other than cost
22 sharing reductions under subsection (c)(2)(A), (B)
23 and (C)) provided under this section out of Federal
24 subsidy payments provided in section 6001. Pay-
25 ments made by health plans to providers shall in-

1 clude appropriate payments for cost sharing reduc-
2 tions.

3 (2) ESTIMATED PAYMENTS, SUBJECT TO REC-
4 ONCILIATION.—Such payment shall be made initially
5 on the basis of reasonable estimates of cost sharing
6 reductions incurred by such a plan with respect to
7 approved families and shall be reconciled not less
8 often than quarterly based on actual claims for
9 items and services provided.

10 **SEC. 5302. APPLICATION PROCESS FOR COST-SHARING RE-**
11 **DUCTIONS AND PREMIUM DISCOUNTS.**

12 (a) IN GENERAL.—A family may apply for a deter-
13 mination of the family adjusted income or wage adjusted
14 income of the family, for the purpose of establishing eligi-
15 bility for cost sharing reductions under section 5301, and
16 for premium discounts and reductions in liability under
17 sections 5103 and 5112.

18 (b) ACTION ON APPLICATION.—

19 (1) IN GENERAL.—States shall act on such ap-
20 plications and ensure due process in a timely man-
21 ner prescribed by the Board.

22 (2) APPROVED FAMILY DEFINED.—As used in
23 this part, the term “approved family” means a fam-
24 ily for which an application under this section has
25 been approved and not yet terminated.

1 (c) HELP IN COMPLETING APPLICATIONS.—Each
2 State shall ensure adequate distribution and assist individ-
3 uals in the filing of applications and income reconciliation
4 statements under this subpart.

5 (d) FAMILY ADJUSTED INCOME.—

6 (1) IN GENERAL.—Except as otherwise pro-
7 vided, in this Act the term “family adjusted income”
8 means, with respect to a family, the sum of the ad-
9 justed incomes (as defined in paragraph (2)) for all
10 members of the family (determined without regard
11 to section 1012).

12 (2) ADJUSTED INCOME.—In paragraph (1), the
13 term “adjusted income” means, with respect to an
14 individual, adjusted gross income (as defined in sec-
15 tion 62(a) of the Internal Revenue Code of 1986)—

16 (A) determined without regard to sections
17 135, 162(l), 911, 931, and 933 of such Code,
18 and

19 (B) increased by the amount of interest re-
20 ceived or accrued by the individual which is ex-
21 empt from tax.

22 (3) PRESENCE OF ADDITIONAL DEPEND-
23 ENTS.—At the option of an individual, a family may
24 include (and not be required to separate out) the in-
25 come of other individuals who are claimed as de-

1 dependents of the family for income tax purposes, but
2 such individuals shall not be counted as part of the
3 family for purposes of determining the size of the
4 family.

5 (e) REQUIREMENT FOR PERIODIC CONFIRMATION
6 AND VERIFICATION AND NOTICES.—

7 (1) CONFIRMATION AND VERIFICATION RE-
8 QUIREMENT.—The continued eligibility of a family
9 for cost sharing reductions, premium discounts and
10 reductions in liability under this section shall be con-
11 ditioned upon the family's eligibility being—

12 (A) confirmed periodically by the State;
13 and

14 (B) verified (through the filing of a new
15 application under this section) by the State at
16 the time income reconciliation statements are
17 required to be filed under section 5303.

18 (2) NOTICES OF CHANGES IN INCOME AND EM-
19 PLOYMENT STATUS.—Each approved family shall
20 promptly notify the State of any material increase
21 (as defined by the Secretary) in the family adjusted
22 income or wage adjusted income of the family.

23 (f) PENALTIES FOR INACCURATE INFORMATION.—

24 (1) INTEREST FOR UNDERSTATEMENTS.—Each
25 individual who knowingly understates income re-

1 ported in an application to a State under this sub-
2 part or otherwise makes a material misrepresenta-
3 tion of information in such an application shall be
4 liable to the State for excess payments made based
5 on such understatement or misrepresentation, and
6 for interest on such excess payments at a rate speci-
7 fied by the Secretary.

8 (2) PENALTIES FOR MISREPRESENTATION.—In
9 addition to the liability established under paragraph
10 (1), each individual who knowingly misrepresents
11 material information in an application under this
12 subpart to a State shall be liable to the State for
13 \$2,000 or, if greater, three times the excess pay-
14 ments made based on such misrepresentation.

15 (g) TERMINATION OF COST SHARING REDUCTION
16 AND PREMIUM DISCOUNTS.—The State shall, after notice
17 to the family, terminate the reduction of cost sharing, pre-
18 mium discounts or reduction in liability for an approved
19 family if the family fails to provide for confirmation or
20 verification on a timely basis or the State otherwise deter-
21 mines that the family is no longer eligible for such reduc-
22 tion.

23 (h) TREATMENT OF AFDC AND SSI RECIPIENTS.—

1 (1) NO APPLICATION REQUIRED.—AFDC and
2 SSI families may not be required to submit an appli-
3 cation under this section.

4 (2) NOTICE REQUIREMENT FOR SSI RECIPI-
5 ENTS.—The Secretary shall notify each State, in a
6 manner specified by the Secretary of the identity
7 (and period of eligibility under the SSI program) of
8 each SSI recipient, unless such a recipient elects (in
9 a manner specified by the Secretary) not to accept
10 the reduction in cost sharing or premium discounts
11 under this part.

12 (i) RULES.—The Secretary shall issue rules related
13 to the application procedure, confirmation and verification
14 of eligibility, ensuring due process in enforcement of pen-
15 alties for inaccurate information, and other issues related
16 to the implementation of cost sharing reductions, premium
17 discounts and reductions in liability under this subpart.

18 **SEC. 5303. END-OF-YEAR RECONCILIATION.**

19 (a) IN GENERAL.—In the case of a family whose ap-
20 plication for a premium discount or reduction of liability
21 for a year has been approved before the end of the year
22 under this subpart, the family shall, subject to subsection
23 (c), file with the State an income reconciliation statement
24 to verify the family's adjusted income or wage-adjusted
25 income, as appropriate, for the previous year. Such a

1 statement shall contain such information as the Secretary
2 shall require. Each State shall coordinate the submission
3 of such statements with the notice and payment of family
4 premium payments.

5 (b) RECONCILIATION OF PREMIUM DISCOUNT AND
6 LIABILITY ASSISTANCE BASED ON ACTUAL INCOME.—
7 Based on and using the income reported in the reconcili-
8 ation statement filed under subsection (a) with respect to
9 a family, the State shall compute the amount of premium
10 discount or reduction in liability that should have been
11 provided under section 5103 or section 5112 with respect
12 for the family for the year involved. If the amount of such
13 discount or liability reduction computed is—

14 (1) greater than the amount that has been pro-
15 vided, the family is liable to pay (directly or through
16 an increase in future family share of premiums or
17 other payments) a total amount equal to the amount
18 of the excess payment, or

19 (2) less than the amount that has been pro-
20 vided, the State shall pay to the family (directly or
21 through a reduction in future family share of pre-
22 miums or other payments) a total amount equal to
23 the amount of the deficit.

24 (c) NO RECONCILIATION FOR AFDC AND SSI FAMI-
25 LIES; NO RECONCILIATION FOR COST SHARING REDUC-

1 TIONS.—No reconciliation statement is required under
2 this section—

3 (1) with respect to cost sharing reductions pro-
4 vided under section 5301, or

5 (2) for a family that only claims a premium dis-
6 count or liability reduction under this subpart on the
7 basis of being an AFDC or SSI family.

8 (d) DISQUALIFICATION FOR FAILURE TO FILE.—In
9 the case of any family that is required to file a statement
10 under this section in a year and that fails to file such a
11 statement by the deadline specified, members of the family
12 shall not be eligible for premium reductions under section
13 5103 or reductions in liability under section 5112 until
14 such statement is filed. A State, using rules established
15 by the Secretary, shall waive the application of this sub-
16 section if the family establishes, to the satisfaction of the
17 State under such rules, good cause for the failure to file
18 the statement on a timely basis.

19 (e) PENALTIES FOR FALSE INFORMATION.—Any in-
20 dividual that provides false information in a statement
21 under subsection (a) is subject to the same liabilities as
22 are provided under section 5302 for a misrepresentation
23 of material fact described in such section.

24 (f) NOTICE OF REQUIREMENT.—Each State shall
25 provide for written notice, at the end of each year, of the

1 requirement of this section to each family which had re-
2 ceived premium discount or reduction in liability under
3 this subpart in any month during the preceding year and
4 to which such requirement applies.

5 (g) TRANSMITTAL OF INFORMATION; VERIFICA-
6 TION.—

7 (1) IN GENERAL.—Each participating State
8 shall transmit annually to the Secretary such infor-
9 mation relating to the income of families for the pre-
10 vious year as the Secretary may require to verify
11 such income under this subpart.

12 (2) VERIFICATION.—Each participating State
13 may use such information as it has available to it,
14 including information made available to the State
15 under section 6103(l)(7)(D)(x) of the Internal Reve-
16 nue Code of 1986, in verifying income of families
17 with applications filed under this subpart. The Sec-
18 retary of the Treasury may, consistent with section
19 6103 of the Internal Revenue Code of 1986, permit
20 return information to be disclosed and used by a
21 participating State in verifying such income but only
22 in accordance with such section.

23 (h) CONSTRUCTION.—Nothing in this section shall be
24 construed as authorizing reconciliation of any cost sharing
25 reduction provided under this subpart.

1 **SEC. 5304. ELIGIBILITY ERROR RATES.**

2 Each State shall make eligibility determinations for
 3 premium discounts, liability reductions, and cost sharing
 4 reductions under sections 5104 and 5123, section 5113,
 5 and section 5301, respectively, in a manner that maintains
 6 the error rates below an applicable maximum permissible
 7 error rate specified by the Secretary (or the Secretary of
 8 Labor with respect to section 5123). In specifying such
 9 a rate, the Secretary shall take into account maximum
 10 permissible error rates recognized by the Federal Govern-
 11 ment under comparable State-administered programs.

12 **TITLE VI—AGGREGATE**
 13 **GOVERNMENT PAYMENTS**
 14 **Subtitle A—Aggregate Federal**
 15 **Payments to Participating State**

16 **SEC. 6001. CAPPED FEDERAL PAYMENTS.**

17 (a) CAPPED ENTITLEMENT.—

18 (1) PAYMENT.—The Secretary shall provide for
 19 each calendar quarter (beginning on or after Janu-
 20 ary 1, 1997) for payment to each participating State
 21 of an amount equal to the capped Federal payment
 22 amount (as defined in subsection (b)(1)) for each
 23 State for the quarter.

24 (2) ENTITLEMENT.—This section constitutes
 25 budget authority in advance of appropriations Acts,
 26 and represents the obligation of the Federal Govern-

1 ment to provide for the payment to States of the
2 capped Federal payment amount under this section.

3 (b) CAPPED FEDERAL PAYMENT AMOUNT.—

4 (1) IN GENERAL.—In this section, the term
5 “capped Federal payment amount” means, for a
6 State for a calendar quarter in a year and subject
7 to paragraph (6) and subsection (e), the amount by
8 which—

9 (A) $\frac{1}{4}$ of the total payment obligation (de-
10 scribed in paragraph (2)) owed to community-
11 rated and experience-rated plans in a State for
12 the year, exceeds

13 (B) $\frac{1}{4}$ of the total amounts receivable (de-
14 scribed in paragraph (3)) by community-rated
15 and experience-rated plans for the year.

16 (2) TOTAL PAYMENT OBLIGATION.—The total
17 payment obligation described in this paragraph in a
18 State for a year is the total amount payable to com-
19 munity-rated and experience-rated plans under title
20 V.

21 (3) TOTAL AMOUNTS RECEIVABLE.—The total
22 amounts receivable in a State for a year is the sum
23 of the following:

24 (A) PREMIUMS.—The amount payable to
25 community-rated and experience-rated plans for

1 the family share of premiums (and premium
2 equivalents), employer premiums (and premium
3 equivalents), and liabilities owed to health plans
4 pursuant to section 6201, not taking into ac-
5 count any failure to make or collect such pay-
6 ments.

7 (B) OTHER GOVERNMENT PAYMENTS.—
8 The amounts payable to health plans under this
9 section and payable under subparagraph (C).

10 (C) PAYMENT TO HEALTH PLANS.—Each
11 participating State is responsible for paying to
12 community-rated health plans a share of its
13 savings under this Act. Such amount shall
14 equal 25 percent of the net reduction in the
15 projected expenditures of the State for health
16 care and related services that the Secretary es-
17 timates the State will experience as the result
18 of the enactment of this Act. A State may re-
19 quest the Secretary to review its estimate and
20 shall be entitled to present its case to the Sec-
21 retary under procedures to be established by
22 the Secretary. This subparagraph shall not be
23 construed as providing a State with a right to
24 bring suit for such payment.

1 (D) ADDITIONAL AMOUNT.—The amount
2 collected by the State under section 1715.

3 (4) NO PAYMENT FOR CERTAIN AMOUNTS.—

4 (A) IN GENERAL.—Each participating
5 State is responsible for the payment of amounts
6 attributable to administrative errors (described
7 in subparagraph (B)).

8 (B) ADMINISTRATIVE ERRORS DE-
9 SCRIBED.—The administrative errors described
10 in this subparagraph include the following:

11 (i) An eligibility error rate for pre-
12 mium discounts, liability reductions, and
13 cost sharing reductions to the extent the
14 applicable error rate exceeds the maximum
15 permissible error rate, specified by the ap-
16 plicable Secretary, with respect to the sec-
17 tion involved.

18 (ii) Misappropriations or other State
19 expenditures that the Secretary finds are
20 attributable to malfeasance or misfeasance
21 by the State.

22 (5) SPECIAL RULES FOR SINGLE-PAYER
23 STATES.—In applying this subsection in the case of
24 a single-payer State, the Secretary shall develop and
25 apply a methodology for computing an amount of

1 payment (with respect to each calendar quarter) that
2 is equivalent to the amount of payment that would
3 have been made to the State for the quarter if the
4 State were not a single-payer State.

5 (6) LARGE GROUP PURCHASERS.—The Sec-
6 retary, in consultation with the Secretary of Labor,
7 shall withhold an appropriate amount from the
8 capped Federal payment amount as may be nec-
9 essary to make payments to plans offered by large
10 group purchasers.

11 (c) DETERMINATION OF CAPPED FEDERAL PAY-
12 MENT AMOUNTS.—

13 (1) REPORTS.—At such time as the Secretary
14 may require before the beginning of each fiscal year,
15 each State shall submit to the Secretary such infor-
16 mation as the Secretary may require to estimate the
17 capped Federal payment amount under this section
18 for the succeeding calendar year (and the portion of
19 such year that falls in such fiscal year).

20 (2) ESTIMATION.—Before the beginning of each
21 year, the Secretary shall estimate the capped Fed-
22 eral payment amount for calendar quarters in such
23 year. Such estimate shall be based on factors includ-
24 ing prior financial experience in the State, future es-
25 timates of income, wages, and employment, and

1 other characteristics of the area found relevant by
2 the Secretary. The Secretary shall transmit to Con-
3 gress, on a timely basis consistent with the timely
4 appropriation of funds under this section, a report
5 that specifies an estimate of the total capped Fed-
6 eral amounts owed to States under this section for
7 the fiscal and calendar year involved.

8 (d) CAP ON PAYMENTS.—

9 (1) IN GENERAL.—The total amount of the
10 capped Federal payments made under this section
11 for quarters in a fiscal year may not exceed the cap
12 specified under paragraph (2) for the fiscal year.

13 (2) CAP.—Subject to paragraphs (3) and (6)—

14 (A) FISCAL YEARS 1997 THROUGH 2000.—

15 The cap under this paragraph for fiscal years
16 1997 through 2000 shall be established by the
17 Secretary, in consultation with the Director of
18 the Office of Management and Budget, not
19 later than 6 months prior to the beginning of
20 fiscal year 1997. The cap for each such fiscal
21 year shall be equal to the estimated increase in
22 revenues and savings provided for by this Act
23 to finance the cost of capped Federal payments
24 under this section.

1 (B) SUBSEQUENT FISCAL YEAR.—The cap
2 under this paragraph for a fiscal year after fis-
3 cal year 2000 is the cap under this paragraph
4 for the previous fiscal year (not taking into ac-
5 count paragraph (3)) multiplied by the product
6 of the factors described in subparagraph (C) for
7 that fiscal year and for each previous year after
8 fiscal year 2000.

9 (C) FACTOR.—The factor described in this
10 subparagraph for a fiscal year is 1 plus the fol-
11 lowing:

12 (i) CPI.—The percentage change in
13 the CPI for the fiscal year, determined
14 based upon the percentage change in the
15 average of the CPI for the 12-month pe-
16 riod ending with May 31 of the previous
17 fiscal year over such average for the pre-
18 ceding 12-month period.

19 (ii) POPULATION.—The average an-
20 nual percentage change in the population
21 of the United States during the 3-year pe-
22 riod ending in the preceding calendar year,
23 determined by the Secretary based on data
24 supplied by the Bureau of the Census.

1 (iii) REAL GDP PER CAPITA.—The av-
2 erage annual percentage change in the
3 real, per capita gross domestic product of
4 the United States during the 3-year period
5 ending in the preceding calendar year, de-
6 termined by the Secretary based on data
7 supplied by the Department of Commerce.

8 (3) CARRYFORWARD.—If the total of the
9 capped Federal payment amounts for all States for
10 all calendar quarters in a fiscal year is less than the
11 cap specified in paragraph (2) for the fiscal year,
12 then the amount of such surplus shall be accumu-
13 lated and will be available in the case of a year in
14 which the cap would otherwise be breached.

15 (4) NOTIFICATION.—

16 (A) IN GENERAL.—If the Secretary antici-
17 pates that the amount of the cap, plus any
18 carryforward from a previous year accumulated
19 under paragraph (3), will not be sufficient for
20 a fiscal year, the Secretary shall notify the
21 President, the Congress, and each State. Such
22 notification shall include information about the
23 anticipated amount of the shortfall and the an-
24 ticipated time when the shortfall will first
25 occur.

1 (B) REQUIRED ACTION.—Within 30 days
2 after receiving such a notice, the President shall
3 submit to Congress a report containing specific
4 legislative recommendations for actions which
5 would eliminate the shortfall.

6 (5) CONGRESSIONAL CONSIDERATION.—

7 (A) EXPEDITED CONSIDERATION.—If a
8 joint resolution the substance of which approves
9 the specific recommendations submitted under
10 paragraph (4)(B) is introduced, subject to sub-
11 paragraph (B), the provisions of section 2908
12 (other than subsection (a)) of the Defense Base
13 Closure and Realignment Act of 1990 shall
14 apply to the consideration of the joint resolution
15 in the same manner as such provisions apply to
16 a joint resolution described in section 2908(a)
17 of such Act.

18 (B) SPECIAL RULES.—For purposes of ap-
19 plying subparagraph (A) with respect to such
20 provisions, any reference to the Committee on
21 Armed Services of the House of Representatives
22 shall be deemed a reference to an appropriate
23 Committee of the House of Representatives
24 (specified by the Speaker of the House of Rep-
25 resentatives at the time of submission of rec-

1 ommendations under paragraph (4)) and any
2 reference to the Committee on Armed Services
3 of the Senate shall be deemed a reference to an
4 appropriate Committee of the Senate (specified
5 by the Majority Leader of the Senate at the
6 time of submission of such recommendations).

7 (6) FAILURE OF THE CONGRESS TO ACT.—If
8 the Congress disapproves the President's rec-
9 ommendations under this section and fails to enact
10 an alternative proposal which is signed to law by the
11 President which is designed to eliminate such short-
12 fall, the Secretary shall provide for a schedule of
13 proportional reductions in discounts to businesses
14 and individuals to be applied by States and an equal
15 reduction in capped Federal payments to States suf-
16 ficient to eliminate the shortfall within a reasonable
17 period of time.

18 (7) METHOD FOR ADJUSTING THE CAP FOR
19 CHANGES IN INFLATION.—If the inflation rate, as
20 measured by the percentage increase in the CPI, is
21 projected to be significantly different from the infla-
22 tion rate projected by the Council of Economic Advi-
23 sors to the President as of October 1993, the Sec-
24 retary may adjust the caps under paragraph (2) so
25 as to reflect such deviation from the projection.

1 **Subtitle B—Borrowing Authority to**
2 **Cover Cash-flow Shortfalls**

3 **SEC. 6101. BORROWING AUTHORITY TO COVER CASH-FLOW**
4 **SHORTFALLS.**

5 The Secretary may make available loans to States in
6 order to cover any period of temporary cash-flow shortfall
7 at a rate of interest determined by the Secretary of the
8 Treasury. Loans under this section shall be repayable with
9 interest over a period not to exceed two years.

10 **SEC. 6102. CONTINGENCIES.**

11 Each State shall provide that any surplus of funds
12 resulting from an estimation discrepancy described in sec-
13 tion 6200(e)(1), up to a reasonable amount specified by
14 the Secretary, shall be used to fund any future shortfalls
15 resulting from such a discrepancy.

16 **Subtitle C—Miscellaneous**
17 **Provisions**

18 **SEC. 6201. SENSE OF THE COMMITTEE ON LABOR AND**
19 **HUMAN RESOURCES.**

20 It is the sense of the Committee on Labor and
21 Human Resources that when the Affordable Health Care
22 for All Americans Act is enacted it should include the fol-
23 lowing provisions:

24 (1) A requirement that States pay premiums
25 for AFDC and SSI recipients at a level established

1 in the same manner as that described in title IX of
 2 S. 1757 (the Health Security Act), as introduced on
 3 November 22, 1993.

4 (2) A requirement that States make mainte-
 5 nance of effort payments to be included in the
 6 amounts receivable under section 6001(b)(3) at a
 7 level established in the same manner as that de-
 8 scribed in title IX of S. 1757 (the Health Security
 9 Act), as introduced on November 22, 1993.



S 168 IS—2

S 168 IS—3

S 168 IS—4

S 168 IS—5

S 168 IS—6

S 168 IS—7

S 168 IS—8